DOCUMENT RESUME

ED 187 934 CE 025 635

TITLE Military Curricula for Vocational & Technical Education. Drug and Alcohol Abuse Classroom Course 17-10.

INSTITUTION Ohio State Univ., Columbus. National Center for Research in Vocational Education.

SPONS AGENCY Bureau of Occupational and Adult Education (DHEW/OE), Washington, D.C.

PUB DATE May 78

NOTE 1,184p.: Parts of this document will not reproduce well due to broken type. For a related document see CE 025 636.

EDRS PRICE MF09/PC48 Plus Postage.

DESCRIPTORS Alcohol Education; *Alcoholism; Behavioral Objectives; *Counseling Techniques; Counselor Training; Course Descriptions; Crisis Intervention; Curriculum Guides; *Drug Abuse; Drug Education; *Drug Rehabilitation; Etiology; Group Dynamics; Hotlines (Public); Human Services; Individual Counseling; Learning Activities; Mental Health; Pharmacy; Postsecondary Education; *Program Administration; Program Development; Referral; *Rehabilitation Counseling; Rehabilitation Programs; Secondary Education; Social Action; Values Clarification; Workbooks

IDENTIFIERS Military Curricula

ABSTRACT

These teaching guides and student study guides and workbooks for a secondary-postsecondary-level course for drug and alcohol abuse program personnel are one of a number of military-developed curriculum packages selected for adaptation to vocational instruction and curriculum development in a civilian setting. Purpose stated for the 292-hour course is to provide instruction in the areas of drug and alcohol abuse, rehabilitation, and education. The course contains two blocks of instruction--Introduction to Social Actions and Basic Skills and Knowledge. Section 1, contained in the first part of the course, "Equal Opportunity and Treatment," (see Note) includes four lessons requiring 66 hours of instruction. Section 2, contained in this document, covers Basic Drug and Alcohol Skills and Knowledge (31 hours), Counseling Techniques (69 hours), Program Management and Application (39 hours), Principles and Techniques of Drug/Alcohol Education (42 hours), and Group Facilitation Techniques (45 hours). The teaching guides contain topic outlines for class presentation along with behavioral objectives, assignments, and group exercises. Contents of the student study guides and workbooks include text materials and some review exercises. (YLB)

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Military Curricula for Vocational & Technical Education

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

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Drug and Alcohol Abuse Classroom Course 17-10

THE NATIONAL CENTER
FOR RESEARCH IN VOCATIONAL EDUCATION
THE OHIO STATE UNIVERSITY

This military technical training course has been selected and adapted by The Center for Vocational Education for "Trial Implementation of a Model System to Provide Military Curriculum Materials for Use in Vocational and Technical Education," a project sponsored by the Bureau of Occupational and Adult Education, U.S. Department of Health, Education, and Welfare.

MILITARY CURRICULUM MATERIALS

The military-developed curriculum materials in this course package were selected by the National Center for Research in Vocational Education Military Curriculum Project for dissemination to the six regional Curriculum Coordination Centers and other instructional materials agencies. The purpose of disseminating these courses was to make curriculum materials developed by the military more accessible to vocational educators in the civilian setting.

The course materials were acquired, evaluated by project staff and practitioners in the field, and prepared for dissemination. Materials which were specific to the military were deleted, copyrighted materials were either omitted or approval for their use was obtained. These course packages contain curriculum resource materials which can be adapted to support vocational instruction and curriculum development.

The National Center Mission Statement

The National Center for Research in Vocational Education's mission is to increase the ability of diverse agencies, institutions, and organizations to solve educational problems relating to individual career planning, preparation, and progression. The National Center fulfills its mission by:

- Generating knowledge through research
- Developing educational programs and products
- Evaluating individual program needs and outcomes
- Installing educational programs and products
- Operating information systems and services
- Conducting leadership development and training programs

FOR FURTHER INFORMATION ABOUT
Military Curriculum Materials
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Military Curriculum Materials for Vocational and Technical Education

Information and Field Services Division

The National Center for Research in Vocational Education

Military Curriculum Materials Dissemination Is . . .

an activity to increase the accessibility of military-developed curriculum materials to vocational and technical educators.

This project, funded by the U.S. Office of Education, includes the identification and acquisition of curriculum materials in print form from the Coast Guard, Air Force, Army, Marine Corps and Navy.

Access to military curriculum materials is provided through a "Joint Memorandum of Understanding" between the U.S. Office of Education and the Department of Defense.

The acquired materials are reviewed by staff and subject matter specialists, and courses deemed applicable to vocational and technical education are selected for dissemination.

The National Center for Research in Vocational Education is the U.S. Office of Education's designated representative to acquire the materials and conduct the project activities.

Project Staff:

Wesley E. Budke, Ph.D., Director
National Center Clearinghouse

Shirley A. Chase, Ph.D.
Project Director

What Materials Are Available?

One hundred twenty courses on microfiche (thirteen in paper form) and descriptions of each have been provided to the vocational Curriculum Coordination Centers and other instructional materials agencies for dissemination.

Course materials include programmed instruction, curriculum outlines, instructor guides, student workbooks and technical manuals.

The 120 courses represent the following sixteen vocational subject areas:

- Agriculture
- Aviation
- Building & Construction Trades
- Clerical Occupations
- Communications
- Drafting
- Electronics
- Engine Mechanics
- Food Service
- Health
- Heating & Air Conditioning
- Machine Shop
- Management & Supervision
- Meteorology & Navigation
- Photography
- Public Service

The number of courses and the subject areas represented will expand as additional materials with application to vocational and technical education are identified and selected for dissemination.

How Can These Materials Be Obtained?

Contact the Curriculum Coordination Center in your region for information on obtaining materials (e.g., availability and cost). They will respond to your request directly or refer you to an instructional materials agency closer to you.

CURRICULUM COORDINATION CENTERS

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DRUG AND ALCOHOL ABUSE

L3ALR73430A

Classroom Course 17-10

Developed by:
United States Air Force

Occupational Area:
Public Service

Development and Review Dates:
May 30, 1978

Target Audiences:
Grade 12-Adult

Print Pages: 1761
Microfiche: 30

Availability:
Curriculum Coordination Centers

Contents:	Type of Materials: Lesson Plans:	Programmed Text:	Student Workbook:	Handouts:	Text Materials:	Audio-Visuals:	Instructional Design: Performance Objectives:	Tests:	Review Exercises:	Additional Materials Required:	Type of Instruction: Group Instruction:	Individualized:	
Section I. Introduction	•		•	•		x	•		•		•		
to Social Action													
Section II: Basic Skills	•		•	•		x	•	•	•		•		
and Knowledge													

X Materials are recommended but not provided.

THE NATIONAL CENTER FOR RESEARCH IN VOCATIONAL EDUCATION
OSU The Ohio State University
1960 Kenny Road
Columbus, Ohio 432
(614) 486-3655

Course Description:

The course is designed to provide instruction in the areas of drug and alcohol abuse, rehabilitation and education. The course consists of 2 sections covering 292 hours of instruction. In microfiche copy, Section I of this course is contained in Section I of the course "Equal Opportunity and Treatment" (17-9).

Section I. - Introduction to Social Actions contains 4 lessons requiring 66 hours of instruction.
Personal Growth and Professional Development (20 hours)
Personality Theory (12 hours)
Psychology of Prejudice (6 hours)
Cross-Cultural Differences and Difficulties (28 hours)

Section II.- Basic Skills and Knowledge contains 5 lesson units covering 226 hours of instruction.
Basic Drug and Alcohol Skills and Knowledge (31 hours)
Counseling Techniques (69 hours)
Program Management and Application (39 hours)
Principles and Techniques of Drug/Alcohol Education (42 hours)
Group Facilitation Techniques (45 hours)

The course contains both teacher and student materials. Printed instructor materials include lesson plans detailing objectives, aides and teaching outline, and group exercises. Student guides contain textural materials and some review exercises.

DRUG AND ALCOHOL ABUSE

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DEPARTMENT OF THE AIR FORCE
HEADQUARTERS 3250 TECHNICAL TRAINING WING (ATC)
(USAF Technical Training School)
Lackland Air Force Base, Texas 78236

DRUG AND ALCOHOL ABUSE CONTROL

COURSE DESIGN/DESCRIPTION: The instructional design for this course is Group/Lock Step. It provides training in personal growth and professional development; structures, duties, and responsibilities; personality theory; administrative duties; psychology of prejudices, cross cultural differences and difficulties; National Institute of Drug Abuse, principles and techniques of drug/alcohol education, mental health terminology; drug/alcohol abuse policies; pharmacology; history and drug/alcohol abuse, drug/alcohol abuse policies;etiology and progressive characteristics of alcoholism; general counseling techniques; values clarification techniques, viable alternatives; program management; guided discussion techniques; supervisor alcohol confrontation model; drug rehabilitation models; and alcohol rehabilitation models.

NOTE: Section I of this course is contained in Section I of the Equal Opportunity and Treatment Course.

The discrepancy of page numbers (Section I ends on page 483 and Section II begins on page 587) is due to the removal of copyrighted material.

SECTION II

Section I of the Drug and Alcohol Abuse Course is contained in Section I of Equal Opportunity and Treatment Course.

The discrepancy of page numbers (Section I ends on page 483 and Section II begins on page 587) is due to the removal of copyrighted materials.

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PLAN OF INSTRUCTION/LESSON PLAN PART I

NAME OF INSTRUCTOR	COURSE TITLE
	Drug and Alcohol Abuse Control
BLOCK NUMBER	**BLOCK TITLE**
II	Basic Skills and Knowledges

1 COURSE CONTENT	2 TIME
1. Drug Pharmacology a. Identify drugs most commonly abused and the physical and psychological effects of each on humans. SUPPORT MATERIALS AND GUIDANCE Student Instructional Materials SW B-II-[illegible]-1[illegible], Drug Pharmacology Audio-Visual Aid 35mm Slides, Drug Pharmacology Training Methods Lecture Group Process Instructional Guidance Define significant drug terms to be used throughout the course units on pharmacology. Identify the major drug classifications and the most common drugs or drug groups in each class. Explain the basic concepts and principles of pharmacology which relate to drug effects on the body. Describe the processes involved in the introduction, distribution, and elimination of drugs in the body. Emphasize how each process impacts on drug effect. Cover each major drug classification, stressing the physiological actions on the body, the major symptoms of use and main dangers associated with use. Use small groups to answer student questions, elaborate on specific items, and clarify vague areas.	

SUPERVISOR APPROVAL OF LESSON PLAN (PART II)

SIGNATURE AND DATE	SIGNATURE AND DATE

PLAN OF INSTRUCTION NUMBER		DATE	PAGE NO.
L3ALR73430B/L30LR7361B/L30ZR7364B	16	30 May 1978	15

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PART II - TEACHING GUIDE

INTRODUCTION (5 Minutes)

ATTENTION

Pharmacology is a science having to do with the effects of chemicals on living things. It is not an exact science; thus, it is plagued with variables and inconsistencies the same as any science dealing with people.

MOTIVATION

An understanding of pharmacology is important. Drugs react within individuals, producing effects, and individuals interact with society. Society, sooner or later, experiences the brunt of the drugs' effects on individuals. A knowledge of pharmacology alone does not provide a solution for solving the drug abuse problem; however, an understanding of drugs does help in dealing with the problem. You will need to understand pharmacology to do the following job tasks:

1. Prevent Drug/Alcohol Abuse through educating your base about the effects drugs can have on them.

2. Perform crisis intervention and telephone counseling.

3. Assist in the identification and classification of drug/alcohol abusers through conducting Social Evaluations and Intake Interviews.

4. Advise commanders/supervisors on drug/alcohol abuse.

OVERVIEW

1. Cover the lesson objectives with the class.

2. Develop the lesson chronology.

a. Pharmacologic terms and classifications.

b. Pharmacologic concepts and principles.

c. The specific drug pharmacology for the seven classes/types of drugs.

d. The variables involved in drug integrity and the types of adulterants used in street drugs.

BODY (7 Hours 45 Minutes)

PRESENTATION

3a. CRITERION OBJECTIVE: Identify drugs most commonly abused and the physical and psychological effects of each on humans.

1. Meaning of important drug terms and the major classifications of drugs as outlined in Air Force Regulation (AFR) 30-2.

a. Define the following pharmacologic terms. (5)

(1) Drug: Any substance which, due to its chemical or physical makeup, changes the structure or function of living things.

(2) Dose: The amount or concentration of drug taken into the body.

(3) Therapeutic dose: A particular dose taken to produce a desired effect; e.g., the dose of morphine required to relieve pain.

(4) Potency: The amount of drug needed to produce a particular response.

(a) The more potent a drug, the smaller the dose needed.

(b) Very potent drugs are usually more dangerous.

(5) Efficacy: The effectiveness of a drug in producing a particular type of response.

(6) Acute effects: The immediate responses occuring with shortterm drug use; e.g., decreased respiration with narcotics.

(7) Chronic effects: The delayed responses occurring with long-term drug use; e.g., alcholic cirrhosis of the liver.

(8) Primary effects: The desired, therapeutic effects wanted from a drug.

(9) Secondary effects: The side effects or adverse reactions occurring with a drug.

(10) Dependence: A common type of effect occurring from the use of those drugs subject to abuse. This includes both psychological/physical dependence, as well as tolerance and withdrawal. It results from a combination of dose, frequency duration of drug use, and parsonal makeup of the individual. (10:721-733)

(11) Psychological dependence (habitation): Can occur with almost any drug. This involves a mental drive for seeking satisfaction or pleasure from a drug. This drive encourages continued drug use, resulting in tolerance and physical dependence. Certain drugs can cause psychological dependence without producing tolerance and physical dependence; e.g., hallucinogens and marijuana.

(12) Tolerance: The need for higher doses in order to produce a given effect.

3

(a) It is thought to involve a change in body chemistry (adaptation) of the individual.

(b) "Cross-tolerance" refers to tolerance existing between different drugs, with a particular class; e.g., between alcohol and barbitutates.

(c) Tolerance results from continued use of certain drugs; e.g., alcohol, barbiturates, narcotics; and is the basis for physical dependence.

(13) Physical dependence (addiction): Occurs through a physical adaptation process, produced by continued presence of a drug in the body.

(a) The mental drive encourages continued drug use.

(b) Tolerance provides a means for increasing dose level in the body, thus stimulating adaptation.

(14) Withdrawal: A pattern of symptoms or signs showing increased activity of the central nervous system (CNS).

(a) Physical dependence is determined by the occurance of withdrawal when drug use is stopped.

(b) The severity depends on the degree of tolerance present before drug use was stopped.

(c) It represents the body's attempt to readjust its chemistry back to normal.

(15) Antagnoism: An interaction of one drug counteracting or neutralizing the effects of another; e.g., 2 + 2 + =0. Narcotic antagnoists (Narcan^{R}) neutralize the effects of all types of narcotics: e.g., heroin, morphine.

(16) Summation: The combined effects of two or more drugs equals the sum total of their individual effects; e.g., 2 + 2 = 4. The combined use of two or more different barbiturates results in summation of effects.

(17) Synergism. Drugs interacting to produce an effect greater than the sum total of the drugs can produce alone; e.g., 2 + 2 = 10. Alcohol together with barbiturates, produces this kind of effect.

b. Describe how drugs are classified.

(1) Drugs are classified in ways that are meaningful to the person doing the classifying.

(a) Physicians - physical effects.

(b) Pharmacists - pharmacology.

(c) Chemists - chemical structure.

(d) Lawyer - legal classification.

(e) Psychologist - behavioral actions.

(f) User - slang names.

(2) AFR 30-2 describes six major drug classifications.

(a) Sedative-hypnotic - barbiturates, alcohol.

(b) Depressants - toluene acetone, naphta, aliphatic acetates, hexane, cyclohesane, and other inhalation

(c) Stimulant - cocaine, amphetamines.

(d) Hallucinogens - lysergic acid diethylamide (LSD), mescaline.

(e) Narcotic - morphine, heroin.

(f) Relaxant/euphoriant - marijuana, hashish.

EVALUATION

1. In your own words, what is a drug?

2. What is synergism?

3. Give the major AF classifications of drugs as outlined in AFR 30-2 and an example of each.

TRANSITION

2. Basic concepts and three general principles in pharmacology and how they relate to drug effects.

a. Discuss the four basic pharmacologic concepts. (4:135-144)

(1) Nature of drug action.

(a) Drugs in and of themselves have no action.

(b) Actions are produced only after a drug is taken into the body.

(c) Drugs act on existing structures and functions to produce effects.

(d) Drugs create nothing that does not already exists.

(2) Characteristics of drug effects.

(a) No drug produce only a single effect.

(b) Any drug can produce a wide range of effects.

(c) Whether an effect is good or bad depends on how the drug is used and what effect is desired.

(3) Properties of dose.

(a) Dose is the main determinant of a drug's effect.

(b) For any drug, there is a dose high enough that toxicity results.

(c) Likewise, for any drug, there exists a dose small enough that no effect is seen.

(d) Therefore, there is no such thing as a "safe" or a "dangerous" drug.'

(e) A drug's effect depends on how it is used, and primarily on the dose used.

(4) Variation between living things.

(a) Response to a given dose will vary between species, as well as within species.

(b) Some main factors involved in this variation include:

1 Drug absorption, distribution, metabolism, and exertion (pharmacodynamics).

2 Age.

3 Sex.

4 State of health.

5 Mental, psychological makeup (set).

7

6 Environmental surroundings (setting).

(c) Response variation curve (slide).

1 Curve A shows a high degree of variation.

2 Curve B exhibits only slight variation.

3 Rarely does a drug produce only a slight variation.

b. Discuss the three general pharmacologic principles. (4: 135-144)

(1) Dose-time-response relations.

(a) All drug effects are dose-time dependent.

(b) For each different effect produced by a drug, the response will vary with the dose and time course involved.

(c) Dose-response curve (slide).

1 Responses are "graded" - responses vary as the dose changes.

2 Drug A is more potent.

3 Drug B has greater efficacy.

(d) Time-response curve (slide).

1 Interval A-E represents the time drug is present in the body.

2 Interval B-D represents the duration of therapeutic effects.

3 Point C is the time of maximal effect.

4 Rising part of the curve results from absorption and dis ribution.

5 Falling part of the curve results from redistribution, metabolism, and excretion.

6 Multiple drug administrations can cause drug accumulation, resulting in toxicity.

(2) Dose-percent response relations.

(a) Demonstrates the variation of responses between living things.

(b) Dose-percent response curve (slide).

1 Sensitive individuals respond to effects of lower doses.

2 Resistant individuals respond to effects of higher doses.

(3) Pharmacodynamics.

(a) Drug enters the body and is absorved into the blood.

(b) Drug in the blood is distrubuted all over the body.

(c) Absorption and distribution cause drug to accumulate at its site of action, producing an effect.

(d) Redistribution, metobolism, and excretion tend to remove drug from its site of action, thus reducing its effect.

EVALUATION

1. In your own words, what are four basic pharmacologic concepts?

2. What are the three general pharmacologic principles?

TRANSITION

3. How drugs are administered to and eliminated from the body and how this relates to the drug effects.

a. Discuss drug administration.

(1) Route of administration influences the onset of drug action.

(2) There are three main routes of administration of drugs.

(a) Oral route.

1 Absorption occurs in the stomach and intestines.

2 Provides the slowest, most inconsistent onset of action.

(b) Inhalation route.

(1) Absorption occurs in the lungs.

2 Provides an intermediate rate of onset.

(c) Injection route.

1 Provides the fastest onset of action.

2 Intravenous (IV) ("mainlining") is the most rapid injection method.

3 Intramuscular (IM) is an intermediate method.

4 Subcutaneous (SC) ("skin-popping") is the slowest method.

b. Discuss drug elimination.

(1) Drug elimination influences the duration of drug action.

(2) There are two primary routes of elimination.

(a) Liver (drugs are metabolized in the liver by enzymes).

(b) Kidney (acts as a strainer; filters drug out of blood and excretes it in the urine).

EVALUATION

1. What are the three main routes of administration?

2. What are the two primary routes of elimination?

TRANSITION

4. Narcotics: Identify Primary pharmacologic action, the major symptoms of the three stages of use, the withdrawal symptoms, and the main dangers of narcotic use. (6:57-65)

a. Describe the most common representative narcotics.

(1) Opium poppy derivatives:

(a) Morphine

(b) Codeine

(2) Semi-synthetic opiate derivatives:

(a) Heroin

(b) Dilaudid

(3) Complete synthetics:

(a) Demerol®

(b) Darvon®

(c) Methadone

b. Describe the medical uses of narcotics.

(1) Analgesic

(2) Antitussive

(3) Antispasmodic

c. Explain that the primary pharmacologic action of narcotics is CNS depression.

d. Discuss the major symptoms of the three stages of narcotic use.

(1) Initial/average dose stage.

(a) Drowsiness, sedation, and narcosis.

(b) Mental clouding.

(a) Lethargy

(b) Apathy

(c) Inability to concentrate.

(c) Euphoria

(d) Unresponsiveness to pain.

(e) Suppression of cough reflex.

(f) Pupillary constriction.

(g) Constipation

(h) Emesis

(1) Depressed respiration.

(2) Acute toxicity stage.

(a) Pupillary constriction/dilation.

(b) Respiratory depression.

(c) Decreased blood pressure.

(d) Unconsciousness/coma.

(3) Chronic use stage.

(a) Dependence.

1 High psychological.

2 High physical.

(b) Tolerance.

(c) Withdrawal.

1 Anxiety/irritability.

2 Watery nose/runny eyes (flu-like).

3 Nausea/vomiting.

4 Muscle/abdominal cramping.

5 Cold, clammy skin (goose-flesh).

6 Tremors.

e. Discuss the main dangers of narcotic use.

(1) Accidental overdose (OD)

(2) High dependence liability.

(3) Infections.

13

(a) Venereal disease (VD).

(b) Hepatitis.

(c) Bacterial endocarditis.

(4) Social deterioration.

(a) Apathy/amotivation.

(b) Crime.

f. Describe the tell-tale signs/paraphernalia of narcotic use.

(1) Needle marks (tracks) with scars.

(2) Glassine envelopes.

(3) Burned bottle caps or spoons.

(4) Blood stains on clothing.

(5) Hypodermic syringe.

(6) Empty bottles of cough syrup.

(7) Pinpoint pupils.

EVALUATION

1. What are some common representative narcotics?

2. What are the major symptoms of the acute toxicity stage?

3. What are the main dangers associated with use of narcotic drugs?

TRANSITION

5. Sedative-hypnotics: Primary pharmocologic action, the major symptoms of the three stages of use, the withdrawal symptoms and the main dangers of sedative-hypnotic use. (7: 108-117)

(a) Describe that most common representative sedative-hypnotics.

(1) Barbiturates:

(a) Nembutal[R]

(b) Seconal[R].

(c) Amytal[R].

(d) Tuinal[R].

(2) Nonbarbiturates:

(a) Chloral hydrate.

(b) Paraldehyde.

(c) Quaalude[R].

(d) Librium[R].

(e) Valium[R].

(f) Meprobamate.

b. Describe the medical uses of sedative-hypnotics.

(1) Anti-anxiety.

(2) Hypnosis.

(3) Anticonvulsant activity.

(4) Muscle relaxation.

(5) Pre-anesthesia.

c. Explain that the primary pharmacologic action of sedative-hypnotics is CNS depression.

d. Discuss the major symptoms of the three stages of sedative-hypnotic use.

(1) Initial/average dose stage.

(a) Drowsiness, sedation, and hypnosis.

(b) Lethargy.

(c) Euphoria.

(d) Loss of inhibitions.

(e) Muscle incoordination.

(f) Impaired judgement.

(g) Depressed respiration.

(2) Acute toxicity stage.

(a) Drowsiness.

(b) Unconsiciousness.

(c) Respiratory depression.

(d) Decreased blood pressure.

(e) Coma.

(3) Chronic use stage.

(a) Dependence.

1 High psychological.

2 High physical.

(b) Tolerance.

(c) Withdrawal.

1 Irritability/insomina.

2 Nausea/vomiting.

3 Muscle weakness cramping.

4 Delirium/psychosis.

5 Tremors.

6 Convulsion.

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e. Discuss the main dangers of sedative-hypnotic us.

(1) Accidental OD.

(2) High dependence liability.

(3) Social deterioration.

(a) Apathy/amotivation.

(b) Crime.

EVALUATION

1. What are some common representative sedative-hypotics?

2. What are the major effects of chronic use of sedative-hypnotics?

TRANSITION

6. Inhalants: Primary pharmacologic action, the major symptoms of the three stages os use, the withdrawal sumptoms, and the main dangers of inhalant use. (5:249-253)

a. Describe the most common representative inhallants.

(1) Benzene.

(2) Halogenated hydrocarbons.

(3) Gasoline.

(4) Paint thinner.

(5) Airplane glue.

(6) Anesthetic gases.

b. Explain that the primary pharmacologic action of inhalants is CNS depression.

c. Discuss the major symptoms of the three stages of inhalant use.

(1) Initial/average dose stage.

(a) Drowsiness,

(b) Euphoria.

(c) Uncoordination.

(d) Loss of inhibitions.

(e) Nausea/vomiting.

(f) Irritation to eyes, nose, and throat.

(2) Acute toxicity stage.

(a) Ringing in the ears.

(b) Blackout (spotty-type amnesia).

(c) Disinhibition excitement, followed by depression.

(d) Delusion/visual hallucinations.

(e) Cryogenic/allergic constriction of air ways.

(f) Sudden death.

(3) Chronic use stage.

(a) Moderate psychological dependence.

(b) Little physical dependence.

(c) Tolerance.

(d) Organ damage.

(e) Withdrawal.

1 Irritability/insomnia.

2 Tremors.

3 Hallucinations.

4 Delirium tremens (DTs).

d. Discuss the main dangers of inhalant use.

(1) Loss of coordination resulting in physical injury.

(2) Organ damage.

(a) Bone marrow.

(b) Liver.

(c) Kidney.

(d) Brain.

(3) Cryogenic/allergic reactions.

(4) Sudden death phenomenon.

EVALUATION

1. What is the primary pharmacologic action of inhalants?

2. What are the main dangers associated with inhalant use?

TRANSITION

7. Stimulants: The primary pharmacologic action, the major symptoms of the three stages of use, the withdrawal sumptoms, and the main dangers of stimulant use. (8:86-97)

a. Describe the most common representative stimulants.

(1) Cocaine.

(2) Amphetamines.

(a) Benzedrine®.

(b) Dexedrine®.

(c) Methamphetamine.

(3) Ritalin[R].

(4) Caffeine.

b. Describe the medical uses of stimulants.

(1) Anorexiant.

(2) Hyperkinetic behavior in children.

(3) Narcolepsy.

(4) Minimal brain dysfunction.

(5) Antidepressant.

c. Explain that the primary pharmacologic action of stimulants is CNS stimulation.

d. Discuss the major symptoms of the three stages of stimulant use.

(1) Initial/average dose stage.

(1) Increased activity/anxiety.

(b) Euphoria.

(c) Decreased fatigue.

(d) Headache.

(e) Dilated pupils.

(f) Tremors.

(g) Heartbeat disturbances.

(h) Increased blood pressure.

(i) Increased sexual drive.

(1) Increased respiration.

2. Acute toxicity stage.

(a) Increased anxiety/ aggressiveness/mania.

(b) Delusions/paranoia/ hallucinations.

(c) Severe heartbeat disturbances.

(d) Increased blood pressure.

(e) Tremors/convulsions.

(f) Respiratory failure.

3. Chronic use stage.

(a) High psychological dependence.

(b) Low physical dependence.

(c) Tolerance.

(d) Psychotic behavior.

(e) Suicidal tendencies.

(f) Lapses of alertness.

(g) Withdrawal (questionable).

1 Post-compensatory, mental depression.

2 Lethargy/somnolence.

3 Abdominal cramping.

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4 Suicidal tendencies.

e. Discuss the main dangers of stimulant use.

(1) Bizarre changes in behavior.

(a) Paranoia/delusions.

(b) Aggressiveness/mania.

(c) Grandiose feelings of power.

(d) Marked impairment of judgment.

(e) Suicidal tendencies.

(2) Infections.

(a) VD.

(b) Hepatitis.

(c) Bacterial endocarditis.

(3) Talc abscesses (Ritalin^{R}).

(4) Gastrointestinal (GI) tract ulcers (caffeine).

(5) Nasal septum perforation (cocaine).

EVALUATION

1. What are some common representative stimulants?

2. What are the medical uses of stimulant drugs?

3. What are the main dangers associated ith stimulant use?

8. Hallucinogens: The primary pharmacologic action, the major symptoms of the three stages of use, the Withdrawal symptoms, and the main dangers of hallucinogen use.

a. Describe the most common representative hallucinogens.

(1) Natural sources.

(a) Peyote cactus - mescaline.

(b) Mushrooms - psilocybin, psilocin.

(c) Toad skin - bufotenin.

(2) Synthetic sources.

(a) Indole class - LSD, DMT, DET.

(b) Catechol class - DOM, MDA.

(c) Miscellaneous - phencylidine.

b. Describe the "proposed" medical uses of hallucinogens.

(1) Psychiatric disorders.

(2) Alcoholism.

(3) "Death therapy."

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c. Explain that the primary pharmacologic action of hallucinogens is an induced change in CNS perceptions.

d. Discuss the major symptoms of the three stages of hallucinogen use.

(1) Initial/average dose stage.

(a) Altered perceptions (Synthesia).

(b) Multi-potential behavior.

(c) Sense of timelessness.

(d) Hallucinations.

(e) Paradoxical/ambivalent symptoms.

(f) Revelations.

(g) Sympathetic predominance.

(2) Acute toxicity stage.

(a) Panic/fear reactions.

(b) Convulsions.

(c) Extreme increases in body temperature.

(3) Chronic use stage.

(a) Low psychological dependence.

(b) No physical dependence.

(c) Rapid tolerance develops in a cyclic manner.

(d) Flashbacks.

(e) No physical signs of withdrawal noted.

e. Discuss the main dangers of hallucinogen use.

(1) Inability to distinguish reality from fantasy.

(2) Panic/fear reactions.

(3) Depressive/paranoid reactions.

(4) Psychotic reactions.

(5) Flashbacks.

(6) Social deterioration.

EVALUATION

1. What are some common representatives of the hallucinogens?

2. What is the primary pharmacologic action of the hallucinogens?

3. What are the main dangers associated with hallucinogen use?

TRANSITION

9. Relaxant/euphoriants: The primary pharmacologic action, the major symptoms of the three stages of use, the withdrawal symptoms, and the main dangers of relaxant/euphoriant use. (1:143-151)

a. Describe the most common representative relaxants/euphoriants.

(1) Marijuana.

(2) Hashish.

(3) Tetrahydrocannabinol.

(a) Six percent content in Indian hemp.

(b) Ten percent in Southeast Asian "pot."

(c) Twenty percent plus in hashish.

b. Describe the "proposed" medical uses of relaxants/euphoriants.

(1) Glaucoma.

(2) Insomina.

(3) Headache.

(4) Terminal diseases.

c. Explain that the primary pharmacologic action of relaxants/euphoriants involves an induced change in CNS preceptions.

d. Discuss the major symptoms of the three stages of relaxant/euphoriant use.

(1) Initial/average dose stage.

(a) Disinhibition

(b) Time distortions.

(c) Synthesia.

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(d) Impaired short-term memory.

(e) Euphoria.

(f) Reddening of the eyes.

(2) Acute toxicity stage.

(a) Nausea/vomiting.

(b) Impaired judgment/ coordination.

(c) Strong (sometimes unpleasant) bodily perceptions.

(d) Hallucinations (pseudo).

(e) Panic states (rare).

(3) Chronic use stage.

(a) Moderate psychological dependence.

(b) No physical dependence.

(c) Possible reverse tolerance in humans.

(d) No physical signs of withdrawal noted.

e. Discuss the main dangers of relaxant/euphoriant use.

(1) Chronic psychological dependence.

(2) Possible social deterioration.

(3) Accidents resulting from altered perceptions.

(4) Psychotic reactions (rare).

(5) Criminal prosecution - imprisonment.

(6) Unknown long-term use effects.

(a) Brain degeneration.

(b) Male impotence.

(c) Loss of immunologic protection gainst infections/ cancer.

(d) Chromosomal damage/ birth defects.

f. Describe the tell-tale signs/ paraphernalia of relaxant/euphoriant use.

(1) Odor of burning rope.

(2) Cigarette papers.

(3) Roach clamp.

(4) Specialized pipes.

EVALUATION

1. What are some common representative relaxants/euphoriants?

2. What is the <u>primary</u> pharmacologic action of relaxants/euphoriants?

3. What are the <u>main</u> dangers associated with use of the relaxants/ euphoriants?

4. What are the tell-tale signs/ paraphernalia associated with relaxants/euphoriants?

TRANSITION

10. NICOTINE (Tobacco): Primary pharmacologic action, the major symptoms of the three stages of use, the withdrawal symptoms, and the main dangers of nicotine (tobacco) use. (2:63-75)

a. Explain that nicotine is used in the form of tabacco products.

b. Describe the different forms of tabacco use.

(1) Cigaretts.

(2) Cigars.

(3) Pipes.

(4) Snuff.

c. Describe the different agents associated ith tobacco smoking.

(1) Nocotine. Lethal dose for a human is about 60 mg.

(2) Tars (carcinogens).

(3) Carbon monoxide.

d. Explain that the primary pharmacologic action of nicotine is low dose, stimulation/high dose, depression of the CNS.

e. Discuss the major symptoms of the three stages of nicotine use.

(1) Initial/average dose stage.

(a) Increased alertness.

(b) Relaxation.

(c) Increased heart rate/blood preasure.

(d) Pupil dilation.

(e) Anorexia.

(2) Acute toxicity stage.

(a) Tremors.

(b) Convulsions.

(c) Respiratory paralysis.

(3) Chronic use stage.

(a) High psychological dependence.

(b) Questionable physical dependence.

(c) Tolerance.

(d) Withdrawal.

1 Increased irritability/anxiety.

2 Headache.

3 Inability to concentrate.

4 Drowsiness.

5 Tremors.

6 Increased hunger.

7 Muscle cramping.

f. Discuss the main dangers of tobacco smoking.

(1) Respiratory effects.

(a) Shortness of breath.

(b) Increased respiratory infections.

(c) Bronchitis

(d) Emphysema

(2) Cordiovascular effects.

(a) Heart beat disturbances.

(b) Increased blood pressure.

(3) Cancer

(a) Mouth

(b) Larynx (throat)

(c) Lungs

EVALUATION

1. What is the primary pharmacologic action of tobacco?

2. What are the different agents associated with tobacco smoking?

3. What are the main dangers associated with tobacco smoking?

TRANSITION

11. Three primary means by which the integrity of a drug can be altered and five types of agents commonly used as adulterants in street drugs. (9:791-798)

a. Define drug integrity.

b. Discuss the three variables involved with drug integrity.

(1) Drug dose/strength
Refers to the amount or percent of the principle drug present.

(2) Drug composition.

(a) Refers to the make-up of a principle drug or drug combination.

(b) Drugs are often misrepresented as being something they are not.

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(3) Drug purity.

(a) Refers to the degree to which a drug is free of impurities or contaminants.

(b) Impurities or contaminants can couse adverse effects.

c. Describe the main types of agents commonly used as adulterants.

(1) Sugars; e.g., lactose, inositol, mannitol.

(a) Inert agents.

(b) Used as fillers.

(2) CNS stimulants; e.g., caffeine, strychnine, ephedrine, phenylephrine, phenylpropanolamine.

(a) Active agents.

(b) Used together with or in place of amphetamines.

(3) Local anesthetics; e.g., procaine, benzocaine, tetracaine, lidocaine.

(a) Active agents.

(b) Used together with or in place of cocaine.

(c) Adverse effects include:

1 CNS stimulation.

2 Convulsions.

3 Hypersensitivity reactions.

(4) Belladonna alkaloids; e.g., atropine, scopolamine.

(a) Active hallucinogens.

(b) Used together with other hallucinogens.

(c) Adverse effects include:

1 Palpitations.

2 Drug mouth.

3 Blurred vision.

4 Constipation.

5 Urinary retention.

6 Hyperthermia.

(5) Antihistamines; e.g., Benadryl, methapyrilene.

(a) Active CNS depressants.

(b) Used together with or in place of sedative-hypnotics.

(c) Adverse effects include:

1 Palpitations.

2 Dry mouth.

3 Blurred vision.

4 Constipation.

5 Urinary retention.

6 Drowsiness.

7 Respiratory depression.

(6) Quinine.

(a) Active agent.

(b) Used as a filler.

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(b) Adverse effects include:

1 "Cinchonism" (tinnitus, visual distrubances, impaired hearing, headache, dizziness, diarrhea, and nausea/vomiting).

2 Hypersensitivity reactions.

3 Tissue irritation.

4 Hypotension.

5 Cardiac depression/arrest.

(7) Salicylates; e.g., Aspirin, salicylic acid.

(a) Active agents.

(b) Used as fillers.

(c) Adverse affects include:

1 "Salicylism" (tinnitus, impaired hearing, dizziness, nausea/vomiting, diarrhea, hallucinations, and acidbase imbalance).

2 Hypersitivity reactions.

3 Local irritation.

(8) Phencyclindine (PCP).

(a) Active hallucinogen.

(b) Used alone or together with LSD, in place of THC, mescaline, psilocybin, and other exotic psychomimetics.

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(c) Adverse effects include:

1 Unpleasant/ frightening hallucinations.

2 Bizarre behavior.

3 Panic/fear reactions.

4 Convulsions

APPLICATION (Select at least three of five secerices. Time 2.5 hours.)

1. Explain that drug abuse patterns in the public at large vary greatly among ethnic and social groups. It is important to understand these differentiations if successful rehabilitation is to be a realistic goal. instruct students to review their course information on the subject of human behavior (psychology, group facilitation, mental health cross-cultural differences, etc), and discuss drug pharmacology as it pertains to ethnic and social groups.

2. Discuss and define the pattern of drug abuse among the following groups represented through out the Air Force rehabilitation program.

a. Youth, ages 16 through 21.

b. White middle-class, male and female.

c. Italian-American

d. Irish-American

e. Black American, middle-class and lower middle-class.

f. Spanish-American, to incluce: Chicano, Cuban, and Puarto Rican.

g. Asian-American.

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3. Discuss the following factors when defining the pattern of common use.

a. Classification of drug most commonly abused and the possible underlying social factors involved relative to selection of drug substance.

b. Basic truths about drugs and their effects on the group or culture as a whole.

c. Commonly-used methods of administration of the drug substance.

d. General physiological actions and symptoms of abuse.

e. Regional patterns of drug abuse, with implications for military personnel as members of ethnic and social groups assigned in the regions identified.

4. Knowing yourself as you do, if you were going to be a drug abuser, what drug would you use? How could we help you with your drug problem? Do not ask students to divulge their past use of drugs.

5. Have two students volunteer, one to act as a drug user, and the other to be the drug-symptom recognizer. Explain that this is not a time to play "stump the band." Have the symptom recognizer leave the room, and tell the user his/her role. Then, have the user leave the room and tell the recognizer his/her role. Put two chairs in the middle of the room, where other students can observe. Let role-playing begin (Attachment 1). Remember to focus on symptoms recognition, rather than counseling techniques.

CONCLUSION (10 Minutes)

SUMMARY

We have discussed the following:

a. The meaning of seventeen important drug terms and six major classifications of drugs as outlined in AFR 30-2.

b. The four basic concepts and three general principles in pharmacology and how they relate to drug effects.

c. How drugs are administered to and eliminated from the body and how this relates to the drug effects.

d. The primary pharmacologic action, the major symptoms of the three states of use, the withdrawal symptoms, and the main dangers of the use of narcotics, sedative-hypnotics, inhalants, stimulants, hullucinogens, relaxants/euphoriants, and nicotine.

e. The three primary means through which the integrity of a drug can be altered and five types of agents commonly-used as adulterants in street drugs.

REMOTIVATION

An understanding of the pharmacologic basis for drug action and the specific facts concerning each of the major drug classifications will prove to be invaluable to you as drug/alcohol educators and counselors. This knowledge will enable you to better interpert drug information and aid you in communicating with your clients, as well as medical personnel.

CLOSURE

Thank you for you attention.

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STUDYGUIDE/WORKBOOK

3ALR73430B/30LR7361B/30ZR7364B-II-1-1

Technical Training

Drug and Alcohol Abuse Control

Drug Pharmacology

16 June 1978

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30ZR7364B-II-1-1
15 June 1978

DRUG PHARMACOLOGY

OBJECTIVES

Identify drugs most commonly abused and the physical and psychological effects of each on humans.

INTRODUCTION

Pharmacology is a science having to do with the effects of chemicals on living things. It's not an exact science, thus it's plagued with variables and inconsistencies the same as any science dealing with people. After all drugs react within individuals, producing effects, and individuals interact within society. Society sooner or later experiences the brunt of the drug effects on the individuals. This point illustrates the importance of pharmacology as it relates to people and drug abuse. A knowledge of pharmacology does not provide a solution for solving the drug abuse problem, however, an understanding of drugs does help in dealing with the problems encountered.

The distinction between drug use and drug abuse can be based on many different types of criteria. Legality is often a primary determinant for differentiating use/abuse. The legal circumstances surrounding the use of a drug involves whether or not the drug is approved by the Federal Drug Administration (FDA) for general marketing, distribution, selling, or investigational use, as well as the manner in which a drug is obtained — by a physician's prescription or on the "street". The legality of a drug also has a major impact on its social acceptability. Another determinant to be considered in assessing the use/abuse of a drug is whether or not it's being used for a valid therapeutic purpose. Merely because a drug s legal does not necessarily mean its use is therapeutically acceptable. All drugs have the potential for producing harmful, as well as beneficial effects. Sound drug therapy is usually initiated only after the potential risks of the drug have been weighed against its possible benefit. This risk-to-benefit ratio applies to all drugs and is useful in assessing the therapeutic purpose for a drug's use. Seven classes/types of drugs will be presented here. Some of these drugs (Lysergic Acid Diethylamide (LSD), heorin, marijuana, etc.) are illegal, have no accepted therapeutic use in this country, and are allowed for use in research only, upon special permission from the FDA. Certain drugs (morphine, barbiturates, amphetamines, etc) are approved for marketing or selling under various legal restrictions, and have accepted therapeutic use in this country. Other drugs (caffeine, nicotine, alcohol, etc.) are approved for general use, are sold over the counter with few, if any, legal restrictions, and have questionable therapeutic use in this country. Just as there are different legal implications associated with use of these drugs, there are also varied instances where their use is of therapeutic value. In addition to studying the pharmacology of these drugs, be aware of the conditions under which they are considered to be used/abused.

upersedes SW 3ALR73430B/30LR7361B/30ZR7364B-II-4-8, 6 August 1976; SW B-II-4-16, August 1977.

DRUG. This can be any substance which, due to its chemical or physical make-up, changes the structure or function of living things.

DOSE. This is the amount or concentration of drug taken into the body.

THERAPEUTIC DOSE. This is a particular dose that is taken to produce a desired effect. For example, it may be the dose of morphine required to relieve pain or the dose of barbiturate needed to produce sleep.

POTENCY. This refers only to the amount of drug (dose) needed to produce a particular response. The more potent a drug is, the smaller the dose needed. As a rule, very potent drugs are usually more dangerous because of the increased risk of overdose. Potency and efficacy (effectiveness) are not the same.

EFFICACY. This is the maximal effectiveness a drug is capable of producing for a particular type of response. The most efficacious drug is not necessarily the most potent.

Drug Effect. This is the action or response resulting from a particular dose of drug acting on the body. There are various terms used to describe the different types of effects.

ACUTE. Acute effects are immediate responses occurring with short term use of a drug, e.g. decreased breathing (respiratory depression) with narcotics.

CHRONIC. Chronic effects are delayed responses occurring with long term drug use, e.g. alcoholic cirrhosis of the liver.

PRIMARY. Primary effects are the desired, therapeutic effects, wanted from a drug.

SECONDARY. Secondary effects are side effects or adverse reactions occurring with a drug.

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DEPENDENCE. This is a common type of effect resulting from the use of those drugs subject to abuse. This term includes both psychological (mental) and physical dependence, as well as the closely associated tolerance and withdrawal. Dependence results from a combination of the dose, frequency and duration of drug use, and personal make-up of the individual. individual.

PSYCHOLOGICAL. Psychological dependence (habituation) can occur with almost any drug. This involves a mental drive for seeking satisfaction or pleasure from a drug. This drive encourages continued drug use, resulting in the development of tolerance and physical dependence. Certain drugs can cause psychological dependence without producing tolerance and physical dependence, e.g. marijuana.

TOLERANCE. This refers to the need for higher doses of drug in order to produce a given effect. Although the basis of tolerance is unknown, it is thought to involve a change in body chemistry (adaptation) of the individual. "Cross tolerance" refers to the tolerance existing between different drugs within a particular class, e.g. tolerance between barbiturates, alcohol and other sedative-hypnotics. With "cross tolerance" the effects of one drug can be substituted for those of another. Tolerance results from the continued use of certain drugs, e.g. alcohol, barbiturates, narcotics, and is the basis for the development of physical dependence.

PHYSICAL. Physical dependence (addiction) occurs through a physical adaptive process produced by the continued presence of a drug in the body. Psychological dependence provides the mental drive, while tolerance furnishes a means for higher increases in dose level in the body, thus stimulating adaptation.

WITHDRAWAL. The presence of physical dependence to a drug is determined by the occurence of withdrawal when use of the drug is stopped. The severity of withdrawal is determined by the degree of tolerance present before use of the drug was stopped. Withdrawal represents a body's attempt to readjust its chemistry back to normal.

Interactions. When two or more drugs are used at the same time, the effect produced will be different from that produced by either drug used alone. Antagonism, summation, and synergism are kinds of interactions seen with combined drug use.

ANTAGONISM. This involves an interaction between drugs such that the effects of one drug trends to counteract or neutralize the effects of another. Narcotic antagonists, such as Narcan^{R}, will neutralize the effects of all types of opiate narcotics, e.g., heroin and morphine.

SUMMATION. Summation exists when the combined effects of two or more drugs equal the sum total of their individual effects. The use of two or more different barbiturates, results in this kind of interaction.

SYNERGISM. This is the ability of drugs to interact and produce an effect greater than either drug can produce individually. The combined use of alcohol and barbiturates exhibits this kind of interaction.

Classification

Drugs can be classified in many different ways depending on what the drug means to the individual doing the classifying. Take the barbiturates as an example. Physicians consider the physical effects of the barbiturates, thus classifying them as sedative-hypnotics. Pharmacists think in terms of their pharmacology, describe them as nonspecific CNS depressants and relate to them as individual agents, e.g., pentobarbital and secobarbital.

Chemists are interested in their chemical structure and place them in the category of barbituric acid derivatives. In the legal sense, lawyers consider them as schedule III controlled drugs. Psychologists are concerned with their behavioral actions, thus classifying them as depressants. At the level of the barbiturate user, slang terms are often applied such as downers or sleepers.

AFR 30-2. This regulation places drugs of abuse into six major classifications (Figure 4-2). These classes, together with examples, include:

1. Sedative-hypnotics - e.g. barbiturates, alcohol.

2. Depressants- e.g., toluene, acetone, naphtha, aliphatic acetate. hexane and cylohexane.

3. Stimulants - e.g., cocaine, amphetamines.

4. Hallucinogens - e.g., LSD, mescaline.

5. Narcotics - e. g., morphine, heroin.

6. Relaxants/Euphoriants - e.g., marijuana, hashish.

EXERCISE I

Complete the following exercise. The correct answers are provided in the Appendix.

1. What is meant by a therapeutic dose?

2. What is the difference between potency and efficacy?

3. How are psychological and physical dependence, tolerance and withdrawal associated with each other?

4. What are the six major drug classifications as defined by AFR 30-2?

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Dangerous Drugs. Drugs most commonly being abused:

Name	*Chemical or Trade Name*	*Classification*	*How Taken*	*Effect Sought*
Dangerous Drugs				
Barbiturates	Phenobarbital Nembutal Seconal Amytal	Sedative-hypnotic	Swallowed or injected	Anxiety reduction; euphoria
Methaqualone	Sopors Mandrax Quaalude	Sedative-hypnotic	Swallowed or injected	Anxiety reduction; euphoria
Amphetamines	Benzedrine Dexedrine Desoxyn Methamphetamine Methedrine	Stimulant	Swallowed or injected	Alertness, activeness
DMT	Diemethyl-triptamine	Hallucinogen	Injected	Exhilaration; distortion of senses
LSD	Lysergic acid diaethylimide	Hallucinogen	Swallowed	Insightful experiences, distortion of senses
STP	4-Methyl-2 demethoxy-amphetamine	Euphoriant; in large doses a hallucinogen	Swallowed	Euphoria; distortion of senses
Mescalin	3, 4, 5 trimeth oxyphenethylamine	Hallucinogen	Swallowed	Exhilaration; distortion of senses
Psilocybin	3 (2-dimethylamine) ethylindol—4 oldihydrogen phosphate (derived from mushrooms)	Hallucinogen	Swallowed	Exhilaration; distortion of senses
Narcotics				
Cocaine	Methylester of benzoylecgenine	Stimulant	Sniffed, injected, or swallowed	Excitation
Codeine	Methylmorphine	Narcotic	Swallowed	Euphoria; prevent withdrawal discomfort
Heroin	Diacetyl Morphine	Narcotic	Sniffed or injected	Euphoria; prevent withdrawal discomfort
Methadone	Dolophine Amidone	Narcotic	Swallowed or injected	Prevent withdrawal discomfort
Morphine	Morphine sulphate	Narcotic	Swallowed or injected	Euphoria; prevent withdrawal discomfort
Marijuana				
Hashish	Cannabis sativa (in a concentrated form)	Relaxant; euphoriant; in large doses a hallucinogen	Smoked	Relaxation; increased euphoria; sociability
Marijuana	Cannabis	(as above)	Smoked Swallowed	(as above)
Substance of Inhalation				
Organic solvents, airplane glues, and aerosol products	toluene, acetone, naphtha, aliphatic acetates, hexane and cyclohexane	Depressant	Inhaled	Euphoria

★**Figure 4–2. Guide to Dangerous Drugs, Narcotics and Marijuana.**

PHARMACOLOGIC CONCEPTS AND PRINCIPLES

Concepts

There are four basic concepts in pharmacology, which provide the basis for principles applied to drugs and their effects. These concepts involve the nature of drug action, the characteristics of drug effects, the properties of dose and the variation between living things.

ACTION. Drugs are inert, chemical substances that in and of themselves have no action. Drug effects are produced only after drugs are taken into the body. In the body, drugs act on existing structures and functions to produce effects. Drugs create nothing in the individual that does not, potentially at least, already exist. For example, alcohol does not create an aggressive person, it merely acts on control systems in the body to release normally existing inhibitions, thus producing aggressive behavioral effects.

EFFECT. No drug produces only a single effect. Any drug can produce a wide range of effects both good and bad. Whether an effect is good or bad depends on the conditions under which the drug is used and on the particular effect wanted from the drug. The opiate narcotics, for example, cause not only euphoria, but also constipation. Opiates are abused for their primary (desired) effect of euphoria and the constipation that develops becomes an unpleasant secondary (side) effect. Medically, a primary effect of opiates, constipation, can be used to treat diarrhea, while the altered state of consciousness (euphoria) becomes a troublesome secondary effect. The secondary effect(s) can be different from the primary effect, as in the above example, or the secondary effect can be an extension (an increased intensity) of the primary. For example, with the barbiturates, the primary

effect wanted might be sedation, but under certain circumstances, side effects can result, such as hypnosis (sleep).

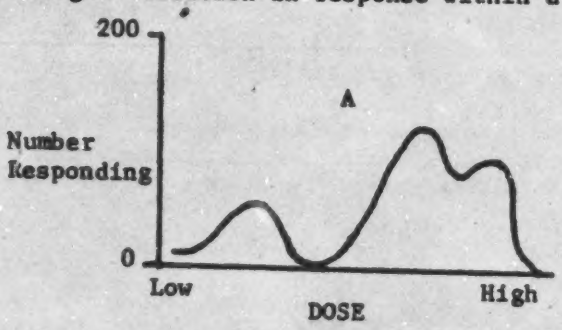
DOSE. Dose is the main determinant of a drug's effect. For any drug, there is a dose high enough such that toxicity results. For example, NaCl (table salt) in large doses can produce such adverse effects as increased blood pressure (hypertension) or water accummulation in tissues (edema). Likewise for any drug, there exists a dose small enough that no effect is seen. For example, the potent poison strychnine, used in extremely low doses produces no effect. Therefore, it can be said that there is no such thing as a "safe" or "dangerous" drug. The drug effect depends on how it's used and primarily on the dose used.

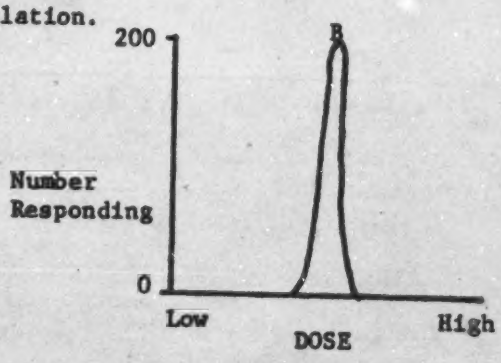
VARIATION. Response to a given dose of drug will vary between species e.g. man and dog, as well as within species, i.e. man and other humans. The basis for this variation between living things is not well understood. Some of the main factors involved in this variation, and which influence the drug effect includes:

1. Drug absorption, distribution, metabolism and excretion (pharmacodynamics).
2. Age.
3. Sex.
4. Genetics.
5. State of health.
6. Mental, psychological make-up (set).
7. Environmental surroundings (setting).

The figures below illustrate the variation of response to different doses of a drug within a population. Hypothetical curve A shows a high

degree of variation in response to drug A, whereas curve B exhibits only slight variation in response to drug B. Rarely does a drug produce only a slight variation in response within a population.



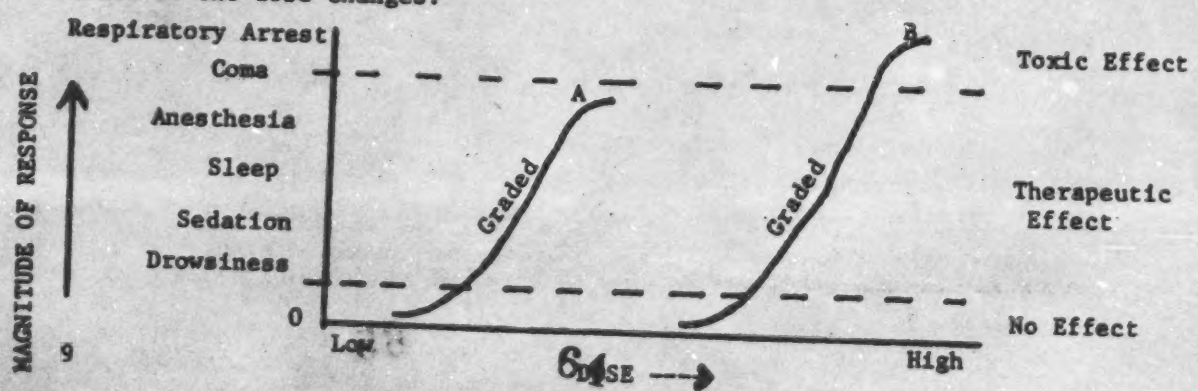


Principles

The concepts mentioned before are closely associated with three general principles involved in drug actions. These principles include dose-time-response relations, dose-percent response relations and pharmacodynamics (drug absorption, distribution, metabolism, and excretion).

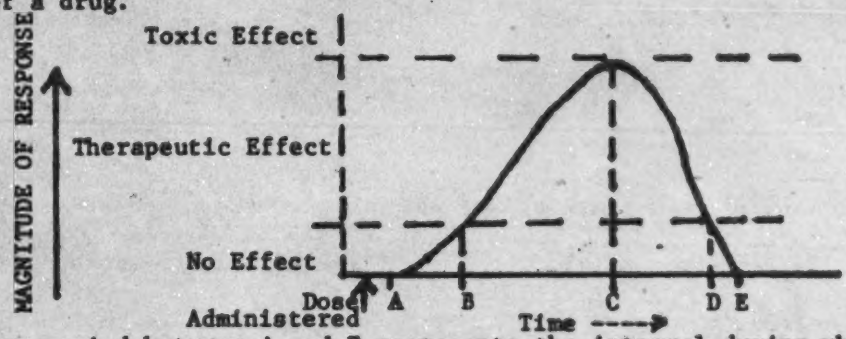
DOSE-TIME-RESPONSE. All drug effects are dose-time dependent. Since no drug has only a single effect, for each different effect produced by a drug, the response will vary with respect to the dose and the time course involved.

DOSE-RESPONSE. To produce an effect, the drug must be present at its site of action in a sufficient concentration (dose). The figure below is a typical dose-response curve, with a range of effects similar to that produced by the barbiturates. The responses are "graded". That is, the response varies as the dose changes.



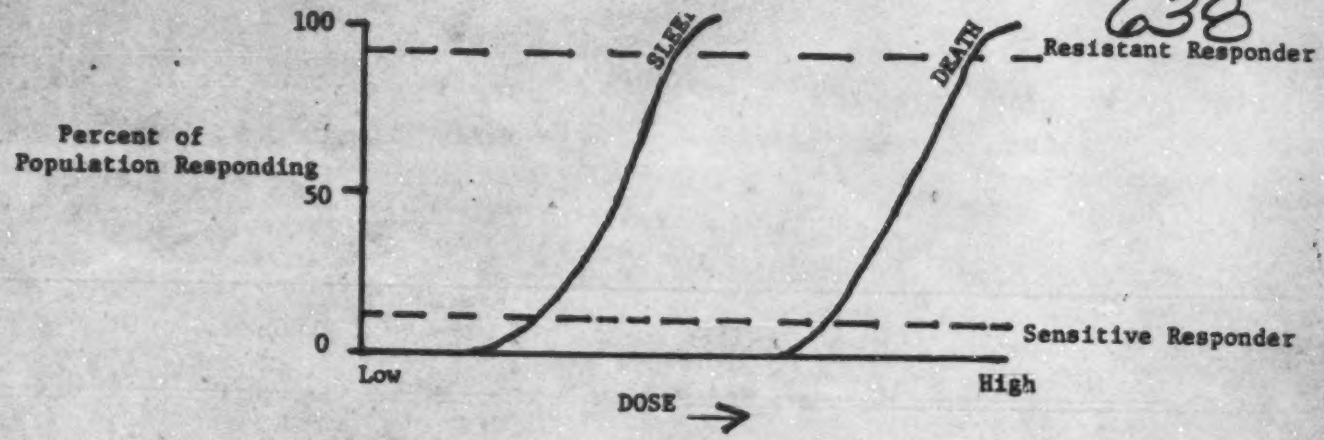
A and B represent hypothetical curves for two barbiturate drugs. The figure shows that drug A is more potent than B, since a lower dose is needed to produce an effect, i.e. sleep. Drug B, however, has greater efficacy than A, because its maximal response is higher.

TIME-RESPONSE. The time course involved in getting a drug to and eliminating it from its site of action also determines the type and intensity of response. The figure below is a typical time-response curve following a single dose of a drug.



The time period between A and E represents the interval during which the drug is present in the body. The interval between B and D represents the duration of therapeutic effect, with point C indicating the time of maximal effect. The rising part of the curve (A-C) results from absorption and distribution processes, while the falling part (C-E) is due to redistribution, metabolism and excretion processes. With multiple drug administrations, giving doses within too short a period of time, i.e. between interval A-E, causes drug accumulation in the body, resulting in toxicity.

DOSE-PERCENT RESPONSE. This relationship demonstrates the variation of responses between living things. The figure below shows the percent of individuals in a poulation that respond to a particular drug effect, i.e. sleep/death, and the dose of drug that is needed to produce that effect. Both sleep and death curves show that some individuals are sensitive to the drug and respond to its effect at low doses. Others are more resistant and respond at higher doses.



PHARMACODYNAMICS. The previous principles rely on the processes of drug absorption, distribution, metabolism, and excretion (pharmacodynamics). A drug enters the body by some route of administration and is absorbed into the bloodstream. Once in the blood, the drug is distributed to various parts of the body. The absorption and distribution processes cause the drug to accumulate at its site of action, thus producing an effect. At the same time these processes are occurring, drug is being redistributed from its site of action to the liver and kidneys. These organs are involved in metabolizing (breaking down) and excreting (removing from the body) the drug. Redistribution, metabolism and excretion tend to lower the level of drug at its site of action, thus reducing its effect. Absorption and distribution, therefore, tend to promote drug action, whereas redistribution, metabolism and excretion provide a means for stopping drug action.

Exercise 2

Complete the following exercise. The correct answers are provided in the Appendix.

1. What is the main point made in each of the four basic pharmacological concepts?

2. What are the three general, pharmacological principles governing drug action?

3. What is a "graded" response?

4. What processes are involved in pharmacodynamics?

DRUG ADMINISTRATION AND ELIMINATION

Administration

Before a drug can be taken up into the blood and carried to its site of action to produce an effect, it must first enter the body. The route of administration influences the onset (beginning) of drug action. There are three main routes of administration important to all drugs. They are the oral, inhalation, and injection routes.

ORAL. With oral administration, absorption occurs in the stomach and intestines. This route provides the slowest and most inconsistent onset of action.

INHALATION. Here the drug is inhaled and absorbed through the lungs. An intermediate rate of onset results from this route.

INJECTION. This route provides the fastest onset of drug action. There are three methods of injection, each varying in their rate of onset.

Intravenous (I.V.). I.V. ("mainlining") puts the drug directly into the blood, resulting in the most rapid onset of action.

Intramuscular (I.M.). I.M. provides an intermediate onset because the good blood supply to muscle causes faster absorption.

Subcutaneous (S.C.). S.C. ("skin popping") provides the slowest onset for an injection method because the poor blood supply to the skin results in slower absorption.

Elimination

Metabolism and excretion processes are involved in removing drug from its site of action, thus stopping the drug effect. There are two primary

routes of elimination. Elimination can occur by either redistribution of a drug from its site of action to the liver for metabolism or to the kidney for excretion.

LIVER. The liver contains many different enzymes, which metabolize drugs, thus deactivating them.

KIDNEY. The kidney acts as a strainer, and filters drugs out of the blood and excrete them in the urine.

Exercise 3

Complete the following exercise. The correct answers are provided in the Appendix.

1. What are the main routes of drug administration?

2. What are the two primary routes of drug elimination?

3. What does "mainlining" refer to?

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NARCOTIC PHARMACOLOGY

General Information

There are numerous narcotic opiates available. Although they may differ in structure, potency, route of administration, efficacy, and oneset and duration of action, their range of potential effects is similar.

SOURCES-REPRESENTATIVES. The narcotics are obtained from three sources:

1. Opium poppy derivatives; e.g., codeine, morphine.

2. Semi-synthetic opium derivatives; e.g., heroin, dilusdid.

3. Complete synthetics; e.g., Demerol , methadone, Darvon .

SLANG TERMS. There are numerous slang ("street") expressions used to denote the various narcotic opiates. Examples include:

1. Heroin: "Snow," "Harry," "horse," "dope," "skag," "H", "junk."

2. Morphine: "Dreamer," "monkey," "Miss Emma."

3. Codeine: "School boy."

4. Dilaudid: "Lords."

5. Methadone: "Dollies," "dolls."

6. Demerol^{R}: "Diane."

ROUTES OF ADMINISTRATION. The narcotic opiates can be used by almost any common route, including:

1. Oral.

2. Inhalation.

3. Injection; e.g., intravenous (IV), intramuscular (IM), subcutaneous (SC).

PHARAPHENALIA. Tell-tale signs of narcotic use include:

1. Needle marks ("tracks"), with scars.
2. Glassine envelopes.
3. Burned bottle caps or spoons.
4. Blood stains on clothing.
5. Cold/clammy skin ("goose flesh").
6. Tremors.

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MEDICAL USES. The narcotics are very useful medically, despite their high abuse potential and high dependence-forming liability. Their primary therapeutic applications involve:

1. Relief of pain (analgesia).

2. Cough suppression (antitussive).

3. Constipation or anti-diarrheal action of narcotics on the body is a drug-induced depression of central nervous system (CNS) functions.

Primary Actions. The primary action of narcotics on the body is a drug-induced depression of central nervous system (CNS) functions.

Stages of Use and Their Symptoms.

The narcotic drugs have a potential for producing a wide range of effects. The type of symptoms seen with narcotic use will depend on factors such as the dose, time course, and biologic variation. The symptoms of narcotic use can be divided into three stages.

INITIAL/AVERAGE DOSE. The symptoms noted at this stage are produced following short-term use of therapeutic doses. The major symptoms of this stage include:

1. Progressive, dose-related CNS depression, leading to drowsiness, sedation, and narcosis.

2. Mental clouding, resulting in lethargy, apathy, and an inability to concentrate.

3. Subjective, altered state of consciousness, termed euphoria ("high").

4. Unresponsiveness to pain (analgesia).

5. Supression of the cough reflex (antitussive).

6. Pupillary constriction (miosis).

7. Constipation (antispasmodic).

8. Vomiting (emesis).

9. Depressed respiration.

10. Excessive sweating.

ACUTE TOXICITY. The symptoms seen at this stage result from short-term (single dose) use of toxic doses. This stage represents the major overdose (OD) symptoms, including:

1. Pupillary constriction (or dilation, if there is a lack of oxygen).

2. Respiratory depression (can lead to arrest).

3. Decreased blood pressure (canproduce shock).

4. Unconsciousness (can progress to coma and death).

5. Pulmonary edema (fluid accumulating in the lungs).

Spedific antidotes; e.g., Nalline^{R}, Narcan^{R}, are used as antagonists, to treat narcotic ODs.

CHRONIC USE. The symptoms produced at this stage result from long-term use of progressively higher doses of drugs. The major symptoms include:

Dependence. High liability for both psychological and physical dependence.

Tolerance. A high degree of tolerance develops to all narcotic effects, except miosis, constipation, and sweating.

Withdrawal. A characteristic withdrawal syndrome is associated with discontimuing chronic narcctic use.

Withdrawal Symptoms.

The withdrawal symptoms are indicative of increased CNS activity, and include:

1. Increased anxiety and irritability.

2. Watery eyes, runny nose (Flu-like symptoms).

3. Nausea/vomiting/diarrhea.

4. Muscle/abdominal cramping.

5. Cold/clammy skin ("goose flesh")

6. Tremors

Although narcotic withdrawal is uncomfortable, going "cold turkey" is seldom, if ever, fatal and does not require medical treatment.

Main Dangers

There are several hazards associated with narcotic use.

ACCIDENTAL OD. Since the integrity (quality/quantity) of "street" drugs in unpredictable, the potential of getting too much drug per dose is great. In addition, interactions with other CNS depressants used simultaneously can result in additive/synergistic effects.

DEPENDENCE. There is high dependence liability associated with all narcotic drugs.

INFECTIONS. The use of non-sterile items in injecting drugs can result in serious infections, such as VD, malaria, hepatitis, tetanus and bacterial endocarditis.

SOCIAL DETERIORATION. Narcotic use can lead to amotivation and apathy on the part of the user. In addition, the high cost of supporting a narcotic "habit" can force the user to commit criminal acts.

Exercise 4

Complete the following exercise. The correct answers are provided in the Appendix.

1. What is the primary pharmacologic action of the narcotics?

2. What factors determine the types of symptoms produced by narcotics?

3. How are narcotic ODs treated?

SEDATIVE-HYPNOTIC PHARMACOLOGY

General Information

There are numerous sedative-hypnotic drugs available. They are second only to alcohol, as the most commonly-used CNS depressant class. This class of

drugs is divided into two groups, based on similarity of chemical structures; the barbiturate and the non-barbiturate sedative-hypnotics.

REPRESENTATIVES. The sedative-hypnotic class includes:

1. Barbiturates.
   a. Pentobarbital (Nembutal^{R}, "Yellows").
   b. Secobarbital (Seconal^{R}, "Reds").
   c. Amobarbital (Amytal^{R}, "Blues").
   d. Tuinal^{R}, ("Rainbows," "Tooies").
2. Non-barbiturates.
   a. Chloral hydrate ("Mickey Finn," "Joy Juice").
   b. Paraldehyde.
   c. Methaqualone (Quaalude^{R}, "Sopors").
   d. Librium^{R}.
   e. Valium^{R}.
   f. Meprobamate (Miltown^{R}).

SLANG TERMS. Other "street" expressions used to denote agents of the sedative-hypnotic class include: "downers," "candy," "goof balls," and "peanuts."

ROUTES OF ADMINISTRATION. Use of sedative-hypnotic drugs involves the oral route and all other methods of the injection route.

MEDICAL USES. The sedative-hypnotic drugs have a variety of therapeutic uses:

1. Relief of anxiety (sedation).
2. Induce sleep (hypnosis).
3. Control seizures (anti-convulsant).
4. Muscle relaxation.
5. Pre-anesthesia.

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PRIMARY ACTION. The primary action of the sedative-hypnotic agents is depression of CNS functions.

Stages of Use and Their Symptoms

The sedative-hypnotic drugs have a potential for producing a wide range of effects. As with any other drug, the effects produced by sedative-hypnotics will depend on factors, such as the dose, time course, and biologic variation. The symptoms of sedative-hypnotics use can be divided into three stages.

INITIAL/AVERAGE DOSE. The symptoms noted at this stage are those produced following short-term use of therapeutic doses. The major symptoms of this stage include:

1. Progressive, dose-related CNS depression, leading to drowsiness, sedation, and hypnosis.

2. Lethargy.

3. Euphoria.

4. Loss of inhibitions.

5. Muscle incoordination.

6. Impaired judgment.

7. Depressed respiration.

The effects at this stage are very similar to the behavioral - performance effects seen with the short-term use of alcohol.

ACUTE TOXICITY. Short-term use of excessive (toxic) doses of sedative-hypnotics results in the types of symptoms seen at this stage. The major symptoms here include:

1. Drowsiness (can progress to unconsciousness, coma).

2. Respiratory depression (can lead to arrest).

3. Decreased blood pressure (can result in shock).

There is no specific antidote for treating sedative-hypnotic toxicity. Supportive means are used to aid respiration and maintain blood pressure and kidney functioning. CNS stimulants (analeptics) are <u>not</u> used to treat depressant OD.

CHRONIC USE. The symptoms produced at this stage result from long-term use of progressively higher doses of drug. The major symptoms include:

Dependence. There is a high liability of both psychological and physical dependence.

Tolerance. Compared to the narcotics, only a moderate degree of tolerance develops to the sedative-hypnotic symptoms and no tolerance develops to the lethal symptoms. Cross-tolerance exists within the sedative-hypnotic class and to alcohol.

Withdrawal. There is a characteristic withdrawal syndrome associated with discountinuing chronic sedative-hypnotic use.

Withdrawal Symptoms.

The withdrawal symptoms of sedative-hypnotics are indicative of increased CNS activity, like those of narcotic withdrawal. However, unlike the narcotics withdrawal from sedative-hypnotic drugs is more dangerous and, without medical treatment, it can be fatal. The symptoms include:

1. Increased irritability/insomnia.
2. Nausea/vomiting.
3. Muscle weakness/cramping.
4. Delirium/psychosis.
5. Tremors.
6. Convulsions.

Main Dangers.

There are several hazards associated with sedative-hypnotic use.

ACCIDENTAL OD. The unpredictable integrity of "street" drugs, the lack of tolerance development be lethal effects, and the additive/synergistic interactions with other CNS depressants, all add up to increasing the risk of OD with sedative-hypnotic drugs.

DEPENDENCE. There is a high dependence-forming liability associated with all sedative-hypnotic drugs.

SOCIAL DETERIORATION. Sedative-hypnotic use can lead to a lack of apathy and motivation on the part of the user. In addition, criminal acts might be committed in association with sedative-hypnotic use.

PREFERRED AGENTS. Those sedative-hypnotic drugs; e.g., Nembutal[R], Seconal[R], Valium[R], Amytal[R], exhibiting a faster onset and shorter duration of action, are often preferred over those agents; e.g., phenobarbital, Librium[R], possessing a slower onset and longer duration of action. A good reason for this preference might be the greater intensity of effect ("high") produced by the shorter acting agents.

USE/ABUSE ASPECTS. Circumstances surrounding sedative-hypnotic use/abuse differ in certain aspects, compared to other drugs; e.g., heroin, hallucinogens, inhalants, stimulants, etc. In most cases, the sedative-hypnotic agent obtained on the "street" is a proprietary item, produced and marketed through legal channels. Since the drug is not manufactured in a clandestine laboratory and not adulterated ("cut"), its integrity is greater. Finally, physicians very often contribute to the use/abuse of sedative-hypnotics by over-prescribing them for ill-defined therapeutic purposes. In many instances, the sedative-hypnotic used/abused was originally obtained legally.

Exercise 5

Complete the following exercise. The correct answers are provided in the Appendix.

1. How does sedative-hypnotic tolerance differ from narcotic tolerance?

2. Compare the contrast the withdrawal syndrome associated with narcotic and sedative-hypnotic agents?

3. What is the treatment for sedative-hypnotic OD?

INHALANT PHARMACOLOGY

General Information

The inhalants (deliriants) represent a heterogeneous class of synthetic chemicals. Inhalant abuse is popular among young, school-age children and inhalants are easily accessible. Many household products; e.g., furniture polish, aerosol sprays, lighter fluid, etc., are subject to inhalant abuse.

REPRESENTATIVES. Chemically, the inhalants are organic hydrocarbons or organic halogenated hydrocarbons. Some common representatives of the group include:

Commercial Solvents; e.g., benzene, acetone, carbon tetrachloride, naphtha, etc., found in gasoline, paint thinner, airplane glue, and cleaning fluids.

Aerosol Propellants; e.g., halogenated hydrocarbons, found in hair sprays, PAM®, deodorants, insecticides, etc.

Anesthetic Gases; e.g., ether, chloroform, nitrous oxide, etc.

ROUTES OF ADMINISTRATION. These agents are inhaled (via mouth or nose) as vapor (fumes) or as an aerosol spray.

MEDICAL USES. Aside from some anesthetic gases and the use of halogenated hydrocarbons as aerosol propellants in certain medications, the inhalants have no valid therapeutic purpose.

PRIMARY ACTION. The primary action of the hydrocarbon inhalants is depression of CNS functions.

Stages of Use and Their Symptoms

The inhalants are CNS depressants, much like the narcotics, sedative-hypnotics, and alcohol. In addition to producing symptoms similar in nature to these other types of drugs, the inhalants have the potential for producing their own unique symptoms.

INITIAL/AVERAGE DOSE. The symptoms noted at this stage result from short-term use of less than toxic doses. The major symptoms here include:

1. Drowsiness.
2. Euphoria.
3. Incoordination.
4. Loss of inhibitions.
5. Nausea/vomiting.
6. Irritation of eyes, nose, and throat.

ACUTE TOXICITY. Short-term (single dose) use of excessive (toxic) doses can result in the following major types of symptoms at this stage:

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1. Ringing in the ears.

2. Blackout (spotty-type amnesia).

3. Disinhibition excitement, followed by varying degrees of depression.

4. Delusions/visual hallucinations.

5. Cryogenic/allergic reactions, constricting air ways.

6. Sudden death from cardiac arrest.

There is no specific antidote for treating inhalant toxicity. Only supportive means are used, to maintain respiration, blood pressure and other vital functions.

CHRONIC USE. The major symptoms observed at this stage result from long-term use of inhalants.

Dependence. There is a moderate degree of psychological dependence associated with inhalant use; however, there is little, if any physical dependence formed.

Tolerance. It takes a long period (weeks/months) of continued use before appreciable amount of tolerance is developed to inhalants.

Organ Damage. Severe and often irreversible damage to bone marrow, liver, kidney, and brain can result form inhalant abuse. Even initial, short-term, heavy exposure to certain inhalants can cause significant organ damage.

Withdrawal. Withdrawal is also a problem associated with chronic use of inhalants.

Withdrawal Symptoms

The withdrawal syndrome associated with the discontinued chronic use of inhalants is similar to that of the sedative-hypnotics and alcohol is some respects. Like these drugs, the symptoms of inhalant withdrawal is indicative of increased CNS excitability. These symptoms include:

1. Increased irritability/insomnia.

2. Tremors.

3. Hallucinations.

4. Delirium Tremors (DTS).

MAIN DANGERS. There are several hazards associated with inhalant use. These hazards include:

PHYSICAL INJURY: resulting from loss of coordination.

ORGAN DAMAGE: bone marrow, liver, kidney, and brain.

CRYOGENIC/ALLERGIC REACTIONS: causing obstruction of air passages and difficulty in breathing; e.g., Freon®.

SUDDEN DEATH PHENOMENON. associated with cardiac arrest, produced by halogenated hydrocarbons; e.g., PAM®.

Nitrate Abuse

Amyl nitrite is a vasodilator drug, used to treat a particular heart disease, known as anginal pectoris. The slang term, "snappers, refers to the fact that the amyl nitrite is contained in small, glass ampules. which must be cracked or snapped open for use. When the ampule if opened. pungent amyl nitrite vapors are released and inhaled. The drug has a rapid onset (less than one minute) and a short duration of action (about fifteen minutes). The major symptoms produced include:

1. Dizziness/fainting.

2. Flushing of the skin.

3. Headache.

4. Increased heart rate/decreased blood pressure.

Physical injury, resulting from fainting, appears, to be the main hazard in its use/abuse. Claims have been made as to its ability to heighten the sexual experience and produce an effect resembling orgasm. These claims, no doubt, foster its abuse. It is very different, pharmacologically, from the the other inhalants, and is mentioned here only because of its abuse potential as an inhalant.

Exercise 6

Complete the following exercise. The correct answers are provided in the Appendix.

1. The initial/average dose stage inhalant symptoms closely resemble what type of drugs?

2. Explain the dependence liability of the inhalants.

3. What are the main dangers associated with inhalant abuse?

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STIMULANT PHARMACOLOGY

General Information

There are numerous stimulant drugs available. They range from the legally restricted, prescription agents; e.g., cocaine, amphetamines, etc., to the nonrestricted caffeine and over-the-counter (OTC) decongestants; e.g., Benzedrex®, Neo-Synephrine®, etc.

REPRESENTATIVES. The stimulant class includes drugs, such as:

1. Cocaine ("coke," "snow," "girl," "dynamite").

2. Amphetamines ("co-pilots," "beans," "jolly babies"); d, l - amphetamine (Benzedrine®, "bennies"); d - amphetamine (Dexedrine®, "dexys"); and methylamphetamine (methadrine®, "speed", "Crystal", "Doe").

3. Ritalin ®.
4. Pemoline
5. Caffeine.

In addition, there are numerous amphetamine-barbiturate combinations; e.g., Desbutal®, Dexamyl®, and amphetamine derivatives; e.g., Preludin®, Tenuate®; used in treating obesity.

SLANG TERMS. Other "street" expressions used in reference to stimulant class drugs include "uppers" and "pep pills." "Speedball" and "stardust" refer to cocaine-heroin combinations.

ROUTES OF ADMINISTRATION. All of the three main routes; e.g., oral, inhalation, and injection, are used with the stimulant drugs.

MEDICAL USES. The stimulants have a variety of therapeutic uses.

1. Appetite suppression (anorexiant).

2. Decrease hyperkinetic behavior in children.

3. Narcolepsy.

4. Mood elevator (antidepressant).

PRIMARY ACTION. The primary action of the stimulants is stimulation of CNS activity.

Symptomatic treatment and support of vital functions in carried out. Anti-psychotic tranquilizers, e.g., Thorazbine R, effectively treat the psychotic reactions, whereas sedative-hypnotic durgs; e.,g., Valium R, Nembutal R, are used to manage convulsion.

CHRANIC USE. The major symptoms resulting from long-term stimulant use include:

Dependence. There exists a high potential for physicological and a low potentioal for physical dependence, with the stimulant drugs. No physical dependance develops to cocaine.

Tolerance. A fairly high degree of tolerance develops rapidly to the effects of most stimulants; especially with the IV use of methamphetamine. No tolerance develops to cocaine.

Psychosis. A psychotic-like behavior, mimicing the paranoid schizophrenic state, can occur with either acute or chronic use of certain stimulants and is usually reversible upon discontinuance of the drug.

Suicidal Tendencies. This is caused by mental depression, which can occur during both chronic use and withdrawal.

Lapses of altertness. Sudden, brief lapses of alertness, called "fatigue breakthrough," can occur periodically, despite continued use of a stimulant.

Withdrawal. The presence of a withdrawal syndrome following discontinuance of chronic stimulant use is controversial.

Withdrawal Symptoms.

There is no withdrawal associated with cocaine; however, there are characteristic symptoms present following the cessation of most stimulants. These symptoms can be interpreted as withdrawal, and they include:

1. Post-compensatory, mental depression.
2. Lethargy/somnolence.
3. Abdominal cramping.
4. Increased hunger (hyperpagia).

Many of these symptoms are indicative of CNS depression.

MAIN DANGERS.

There are several hazards associated with the use of stimulant drugs.

Stages of Use and Their Symptoms

The stimulant drugs have the potential for producing a wide range of symptoms. As with the other drugs, the type and degree of symptom produced will depend on such factors as dose, time course, and biologic variation.

INITIAL/AVERAGE DOSE. The symptoms produced at this stage result from short-term use of therapeutic doses. The major symptoms here include:

1. Increased activity/anxiety.
2. Euphoria.
3. Decreased fatigue; increased physical performance.
4. Headache.
5. Dilated pupils (mydriasis).
6. Tremors.
7. Heartbeat distrubances.
8. Increased blood pressure.
9. Increased respiration rate.
10. Appetite suppression.

ACUTE TOXICITY. Short-term use of toxic doses can result in the following major symptoms at this stage:

1. Increased anxiety/aggressiveness/mania.
2. Psychotic-like behavior, characterized by delusions, paranoia, and hallucinations (primarily auditory in nature).
3. Severe heartbeat disturbances.
4. Extreme increases in blood pressure (can result in bursting of blood vessels in the brain, eye).
5. Tremors, progressing to convulsions.
6. Post convulsive depression with possible respiratory failure.

There is no specific antidote for treating stimulant toxicity.

BIZARRE CHANGES IN BEHAVIOR. These changes are characterized by:

1. Aggressiveness/mania.

2. Delusions/paranoia/hallucinations.

3. Grandiose feelings of power.

4. Marked impairment of judgement.

5. Suicidal tendencies.

BEING "HUNG UP." The associated psychotic reaction has been discussed previously. In addition, there can exist an irrational pattern of behavior, termed "being hung-up." In this case, an individual will continually repeat a task, such as opening and closing a door, for hours on end.

INFECTION. The use of non-sterile material/devices for injecting stimulant drugs can result in infections such as VD, malaria, hepatitis, tetanus, and bacterial endocarditis.

CARDIOVASCULAR DISTURBANCES. These would include heart beat abnormalities and increases in blood pressure.

POST-COMPENSATORY, Mental depression. This results following discontinuation of chronic stimulant use and can foster suicidal tendencies.

TALC ABSCESSES. This results when stimulant preparations, not intended for IV use, are injected and cause damage to the blood vessels. This is common with Ritalin tablet preparations.

GI TRACT ULCERS. This can be caused by the use of caffeine, which irritates the GI tract lining.

NASAL SEPTUM PERFORATION. Inhalation use ("snorting") of cocaine can cause this type of damage to the air passages of the nose

Exercise 7

Complete the following exercise. The correct answers are provided in the Appendix.

1. What types of drugs can be used to treat the symptoms of stimulant toxitity?

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2. How does stimulant withdrawal differ form narcotic or sedative-hypnotic withdrawal?

3. Describe the psychotic reaction associated with stimulant use.

HALLUCINOGEN PHARMACOLOGY

General Information

A variety of hallucinogenic (psychotomimetic, phantasticant) drugs have been developed and experimented with over the years, since Dr Albert Hofmann first reported his experience with lysergic acid diethylamide (LSD) in the early 1940s. All hallucinogens, whether derived from natural or synthetic sources, have the potential for producing a similar range of symptoms. Differences among the hallucinogens mainly have to do with potency, time course of action, and the incidence and degree of particular types of symptoms.

REPRESENTATIVES. Some common representative hallucinogens are presented here, along with their slang expressions.

1. Natural source:

   a. Peyote cactus - mescaline ("button," "moon," "big chief").

   b. Mushroom - psilocybin, psilocin.

   c. Toad skin - bufotenin.

2. Synthetic source:

   a. Catechol class are all amphetamine derivatives (dimethoxy methamphetamine (DOM, "Serenity-Tranquility-Peace," STP); methydioxy amphetamine ("Mellow Drug of America", MDA, "love drug"); para-methoxy amphetamine (PMA).

   b. Indole class:

      (1) Lysergic acid diethylamide (LSD, "acid," "zen," "sugar").

      (2) Dimethyltryptamine (DMT, "45-minute psychosis").

      (3) Diethyltryptamine (DET).

   c. Miscellaneous class: Phencyclidine (PCP, Sernylan^{R}, "peace pill").

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ROUTES OF ADMINISTRATION. All three main routes can be used for the administration of hallucinogens.

MEDICAL USES. Since most of the hallucinogens are not approved for use by the FDA, only "proposed" therapeutic uses can be considered, as determined by investigational research. These uses apply mainly to LSD.

1. "Death therapy" for terminal disease patients.

2. Treatment of alcoholism.

3. Psychiatric disorders.

Phencyclidine is commercially marketed as an animal tranquilizer, but has a paradoxical, reverse effect on humans. In addition, mescaline (peyote) is approved for use in religious ceremonies by the Native American Church.

PRIMARY ACTION. The primary action of the hallucinogens is to induce changes in CNS perceptions.

Stages of Use and Their Symptoms

The symptoms of the hallucinogens are primarily psychological in nature, as compared to the predominately physiological symptoms produced by the other types of drugs discusses so far. In dealing with psychological, subjective responses, the set and setting factors play an important role in determining the type and degree of symptoms produced. Dose, time course, and biologic variation are also important determinants as to the symptom produced.

INITIAL/AVERAGE DOSE. The symptoms noted at this stage are produced following short-term use of therapeutic doses. The major symptoms of this stage include:

1. Altered perceptions (synethesia); e.g., hearing colors, seeing sounds.
2. Multi-potential behavior; e.g., emotional swings back and forth between panic and tranquility.

3. Relative sense of timelessness; e.g., no distinction between past, present, and future. Time seems to pass by rapidly.

4. Increased sensitivity to stimuli.

5. Hallucinations, primarily pseudo in nature.

6. Paradoxical/ambivalent symptoms - simultaneous, conflicting feelings; e.g., feeling happy and sad at the same time.

7. Revelations - gaining deep personal insight, intensified creativity, and claims of religious/mystical associations.

8. Sympathetic nervous system predominance. This is the primary physiological action noted. It is characterized by increases in heart rate, temperature, blood pressure, and blood sugar; also mydriasis.

ACUTE TOXICITY. The symptoms seen at this stage result from adverse reactions to short-term (single dose) use of hallucinogens. The major symptoms here include:

1. Panic/fear reactions.

2. Convulsions.

3. Extreme increases in body temperature (hyperthermia). A particular case involving an LSD OD resulted in temperatures as high as 106.7°F.

As with many other drugs, there is no specific antidote for treating hallucinogen toxicity. Symptomatic treatment is undertaken to support vital functions. "Talking-down" an individual from a "bad trip" has proved to be very effective. Here, the individual is talked to in a calm, reassuring manner in order to relieve the fears and anxiety the individual is experiencing. At the same time, sensory stimuli; e.g., light, sound, touch, etc., are kept to a minimum. The use of sedative-hypnotic drugs; e.g. Valium^{R}, Seconal^{R}, can aid in sedation and the management of convulsions. Anti-psychotic tranquilizers; e.g., Thorazine^{R}, used to be popular antidotes for treating "bad trips"; however, this mode of treatment was found to result in severe decreases in blood pressure, was psychologically disruptive, and was associated with a higher incidence of flashbacks.

CHRONIC USE. The symptoms seen at this stage result from long-term use of hallucinogens.

1. Dependence. There is a low psychological dependence liability associated with the hallucinogens. No physical dependence has been noted.

2. Tolerance. Tolerance develops rapidly, to a high degree, in a cyclic manner. Tolerance builds with frequent/daily use, and then is rapidly lost, after the drug is discontinued.

3. Flashbacks. These are mini-trips, which occur without warning, and are transient in nature, lasting only a few minutes.

They are usually harmless, but can be disruptive/frightening. They can occur up to eighteen months after the last dose, and are often trigger by physical/psychological stress situations.

4. Withdrawal. No characteristic withdrawal syndrome has been associated with the discontinuance of chronic hallucinogen use.

MAIN DANCERS

The hazards associated with hallucinogens are include?

1. Inability to distingui h reality from fantasy.

2. Panic/fear reactions can lead to suicidal acts.

3. Depressive/paranoid reactions can also lead to suicide.

4. Psychotic reactions.

5. Flashbacks.

6. Social Deterioration.

7. Hallucinations (Pseudo type)".

TYPES OF HALLUCINATIONS. Generally speaking, there are two types of hallucinations to be considered, true- and pseudo-hallucinations. True-hallucinations involve visualizing something; thinking that it actually exists, but, in reality, it does not. This type is characteristic of alcohol withdrawal hallucinations. Pseudo-hallucinations involve visualizing what exists, but doing so in manner which distorts/misinterprets what is seen. The individual, however, does not accept it as being real and is aware that it is a drug-induced phenomenon. This type is characteristic of the hallucinations produced by the hallucinogen class.

Exercise 8

Complete the following exercise. The correct answers are provided in the Appendix.

1. What is the primary nature of hallucinogenic symptoms?

2. What measures are taken to treat an individual experiencing a "bad trip?"

3. What type of hallucinations are primarily experienced with the hallucinogens?

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RELAXANT/EUPHORIANT PHARMACOLOGY

General Information

The relaxant/euphoriants refer to a type of drug derived from the hemp plant, cannabis sativa. The active ingredient in this plant is thought to be Δ 9 tetrahydrocannabinol (Δ9 THC). The potency of these agents is related to their Δ 9 THC content, and the Δ 9 THC content varies within a particular portion of the plant; e.g., leaves, stems, flower, the plant strain, and the growth conditions in which the plant is cultivated.

REPRESENTATIVES. The common representatives within this class include:

1. Marijuana ("loco weed," "Mary Jane," "Texas tea," "grass," "Acapulco gold") is probably the most common.

2. Hashish ("hash").

3. Δ 9 THC:

   a. Up to 6% content in Indian hemp.

   b. Ten percent content in Southeast Asian "pot".

   c. Twenty percent plus in hashish.

ROUTES OF ADMINISTRATION. These agents are used orally, as well as inhaled through smoking. Agents are several times more potent when used orally. Δ 9 THC can be used by injection.

MEDICAL USES. The relaxant/euphoriant drugs, like the hallucinogens, are not approved for general use by the FDA. Experimental use to these agents in research has indicated several possible therapeutic uses:

1. Glaucoma.

2. Insomnia.

3. Severe headaches.

4. Block vomiting (antiemetic) in cancer chemotherapy.

5. Asthma.

PARAPHERNALIA The tell-tale signs of relaxant/euphoriant use include:

1. Odor of burning rope.
2. Cigarette papers.
3. Roach Clip.
4. Specialized Pipe.

Primary Action. The primary action of the relaxants/euphoriants is to induce changes in CNS perceptions.

Stages of Use and Their Symptoms

The type and degree of symptoms is similar between the different relaxants/euphoriants and are dependent on factors such as dose (the Δ^9 THC content), time course, and biologic variation. Since many of the responses are psychological/subjective in nature, set and setting factors are also important determinants.

INITIAL/AVERAGE DOSE. The symptoms seen at this stage result from short-term use of therapeutic doses. The major symptoms here include:

1. Disinhibition.

2. Time/space distortions; e.g., time periods seem longer and spaces appear smaller than they are.

3. Synethesia.

4. Impaired short-term (immediate) memory.

5. Euphoria.

6. Reddening of the eyes, due to smoke irritation (conjunctival injection).

7. Increased hunger; especially a craving for sweets.

ACUTE TOXICITY. The short-term (single dose) use of excessive (toxic) doses results in the following major symptoms at this stage:

1. Nausea/vomiting.

2. Impaired judgment/coordination.

3. Strong/unpleasant bodily perceptions.

4. Hallucinations (pseudo).

5. Panic states (rare).

There is no specific antidote for treating relaxant/euphoriant toxicity. Toxic reactions are dose (Δ^9 THC content) related and highly individualized. Some users will regularly experience adverse reactions, while others never do. These agents have demonstrated a low degree of toxicity in many animal species. In rats, the lethal

dose of Marijuana is roughly 1000 times greater than that of alcohol.

CHRONIC USE. The long-term use of relaxant/euphoriant agents can result in the following major symptoms.

1. Dependence. There is a moderate degree of psychological dependence but apparently no physical dependence associated with these agents.

2. Tolerance. It has been suggested that a reverse tolerance might develop to the effects of relaxant/euphoriant drugs. Whether this reverse tolerance results from an actual adaptation process or merely a learned behavior to a subjective response is presently unknown.

3. Withdrawal. There is no withdrawal syndrome associated with the relaxant/euphoriant agents.

Main Dangers

The hazards associated with use of relaxant/euphoriant drugs are numerous and, in many cases, the claims are questionable or ill-defined

DEPENDENCE. Chronic psychological dependence can occur, although physical dependence and withdrawal syndrome have not been established.

SOCIAL DETERIORATION. Amotivation, apathy, personal neglect, as well as other signs of social deterioration, have been claimed to result from the use of relaxant/euphoriant drugs.

ACCIDENTS. Physical injury due to accidents caused by the effects of altered time/space perceptions can occur. For example, when driving an automobile under the influence of a relaxant/euphoriant drug, speeds seem faster and spaces seem smaller than they actually are. An individual thus tends to over compensate for these altered perceptions, resulting in slower speeds and difficulty in maneuvering the vehical.

PSYCHOSIS. Psychotic reactions tend to be rare and individualized, suggesting that set, setting, and underlying mental disorders may play an important role in the development of this type of reaction.

LEGALITY. The use, possession, or sale of these agents is illegal. Criminal prosecution can result in a severe fine and/or imprisonment.

HERBICIDE POISONING. Marijuana obtained from certain sources, (primarily) Mexico), is sprayed with a herbicide (weed killer) - paraquate. Paraquate is highly toxic, such that ingestion or inhalation of one-tenth of an ounce can cause severe organ damage and death. Other effects included damage to lung tissue, difficulty breathing, vomiting, mouth ulcers, and sever headaches.

UNKNOWN EFFECTS. The long-term effects of these agents are unknown. Numerous claims have been made as to the occurance of chronic, adverse effects; yet, there remains much contradictory material in the literature. These claims include effect such as:

1. Cerebal atrophy (brain degeneration).
2. Male impotence and sterility.
3. Loss of immunologic protection against infections and cancer.
4. Chromosomal damage and birth defects.
5. Cancer.

Exercise 9

Complete the following exercise. The correct answers are provided in the Apendix.

1. What is being referred to when speaking of the dose of a relaxant/euphoriant?

2. The relaxant/euphoriant withdrawal syndrome is characterized by what type of symptoms?

3. What are the main dangers of relaxant/euphoriant use?

NICOTINE PHARAMACOLOGY

General Information

Nicotine is primarily used in the form of tobacco products. Form of tobacco use include:

1. Cigaretts.
2. Cigars.
3. Pipes.
4. Snuff.
5. Chewing.

The range of symptoms produced by nicotine is similar among these different forms of tobacco use.

AGENTS. Hundreds of different agents have been found to be associated with tobacco products. For practical purposes here, these agents can be condensed into three types:

1. Nicotine. This agent is present in all forms of tobacco and in all methods of tobacco use.

2. Carbon monoxide. This is a common agent resulting from the combustion (burning) of organic materials, like tobacco. This agent produces harmful effects by removing oxygen from the blood, thereby decreasing the oxygen supply to various parts of the body.

3. Tars. This term includes the vast majority of agents present in tobacco. A common property, of primary significance, existing within this group of agents is their cancer-producing (carcinogenic) potential. The irritant action of tobacco is also attributed to this group.

4. Hydrogen Cyanide gas. Resulting from the combustion of tobacco.

ROUTES OF ADMINISTRATION. Tobacco products, and the agents associated with them, are used orally, as well as inhaled through smoking and sniffing. Inhalation is a very effective means of getting the tobacco agents into the body.

MEDICAL USE. Although, historically, tobacco was used for a variety of medical purposes; eg., toothache, labor pains. Today, there is no accepted therapeutic value attached to tobacco and its associated agents. Nicotine is useful as a laboratory "tool" in research and in the past, has been widely used as an insecticide.

PRIMARY ACTION. The primary action of nicotine is CNS stimulation at low doses and CNS depression at higher doses. CNS stimulation is the predominate action noted from nicotine used in the form of tobacco.

Stages of Use and Their Symptoms

Since nicotine is used primarily in the form of tobacco by a large portion of the population, it is necessary to distinguish between nicotine symptoms and those produced by other tobacco associated agents. Nicotine symptoms will be covered here, unless otherwise specified.

INITIAL/AVERAGE DOSE. The symptoms noted at this stage result from short/term use of relatively low doses. The major symptoms here include:

1. Increased alertness.

2. Relaxation.

3. Increased heart rate/blood pressure.

4. Dilated pupils.

5. Anorexia.

The nicotine symptoms at this stage closely resemble those produced by the stimulant drugs.

ACUTE TOXICITY. Short-term exposure to excessive doses results in the following major symptoms at this stage: These effects can result from exposure to nicotine insecticides or oral ingestion of tobacco; especially by children.

1. Tremors.

2. Convulsions.

3. Respiratory paralysis.

Aside from symptomatic treatment, there is no specific antidote for treating nicotine toxicity.

CHRONIC USE. The long-term use of nicotine can result in the following major symptoms:

1. Dependence. There is a high degree of psychological dependence associated with the use of nicotine. The potential for physical dependence is questionable.

2. Tolerance. A moderate degree of tolerance may develop to the symptoms of nicotine.

3. Withdrawal. A characteristic pattern of withdrawal symptoms has been associated with the discontinuance of chronic nicotine use. These symptoms include:

a. Increased irritability/anxiety.

b. Headache.

c. Inability to concentrate.

d. Drowsiness.

e. Tremors.

f. Increased hunger.

g. Muscle cramping.

Main Dangers

The main dangers of nicotine use are closely interrelated with the hazards of tobacco use; in particular tobacco smoking. The different agents associated with tobacco are all involved to varying degrees in producing these hazards.

RESPIRATION. The respiratory symptoms of tobacco smoking are due in part to all four types of assoicated agents. These symptoms include:

a. Shortness of breath

b. Increased respiratory infections.

c. Bronchitis.

d. Emphysema.

CARDIOVASCULAR PROBLEMS. The effects on the heart and blood vessels result largely from nicotine. The symptoms include:

a. Heartbeat disturbances.

b. Increased blood pressure.

c. Ischemic heart disease.

CANCER. An increased incident of cancer in cigarette smokers has been established. How smoking causes cancer is, however, unknown. The "tars" associated with tobacco have been shown, experimentally, to be carcinogenic. The kinds of cancer associated with smoking include:

a. Lung.

b. Larynx. (throat)

c. Mouth

TOXICITY. Nicotine, itself, is one of the most toxic substances known to man. The estimated lethal dose for man is about 60 mg. An average cigarette contains 20-30 mg; whereas, an average cigar contains roughly 120 mg of nicotine. The amount of nicotine that actually enters the body, however, is only a small percentage of the total contained in the cigarette or cigar. This percentage is variable and depends on such factors as:

1. Whether the tobacco is smoked (inhaled) or chewed (orally).

2. The amount actually inhaled or swallowed.

3. The type of tobacco.

4. The size (length) of the cigarette or cigar.

5. The presence or absence of a filter.

Exercise 10

Complete the following exercise. The correct answers are provided in the Appendix.

1. The initial/average dose stage symptoms of nicotine closely resemble those of what class of drugs?

2. What types of agents are associated with the main dangers of tobacco use?

3. Nicotine is largely responsible for what main danger of tobacco use?

STREET DRUG INTEGRITY AND COMMON ADULTERANTS

The old saying, "you get what you pay for," does not always hold true, especially in regards to the "black market" or "street" drugs. These drugs, which are manufactured to illicit, clandestine laboratories and/or procurred through illegal channels, can vary considerably in their integrity. Adulterating or "cutting" a principle drug with other types of agents can result in unexpected adverse effects for the user and profits for the pusher.

Integrity

Drug integrity is what the user expects the drug to be, based on what the drug is represented as being. The integrity of a drug product involves both its quantity (dose or strength) and quality (composition and degree of purity). Variation in any or all of the these three drug variables (dose/strength, composition, and purity) affect a drug's integrity.

DRUG DOSE/STRENGTH. This refers to the amount or precent of a drug present in a given unit ("hit," "bag," "lid") or dosage form (capsule, tablet). Adulterating or "cutting" a given amount of a principle drug, with another agent(s) will result in a lesser amount of the principle drug in a given unit. For example, if you were to divide 12mg. of 100% heroin into 4 mg. units ("hits"), you would contain only half as much heroin. Analysis for determinating and the quantity (amount) of drug present are often more difficult and involved than that required to determine the quality (kind) of a drug. Thus, in many instances you know what you have got, but you do not know how much. For example, street dosages of LSD may vary from 0.02 mg. to 0.6 mg; the dose you could mean the difference between a "good" or a "bad: trip.

DRUG COMPOSITION. This refers to the make-up of a principle drug or drug combination. Street drugs are often misrepresented and

In one recent study, laboratory analysts of street drug samples indicated that 51% of the samples did not contain any of the drug they were alleged to contain, while 41% did contain the principle drug they were supposed to contain. In addition, 4% contained not only the alleged principle drug, but also some other agent(s) (adulterants). No definite answer could be obtained for the remaining 4% of the samples tested.

The greatest degree of misrepresentation (or deception), pertaining to drug composition were found to occur with drugs alleged as being either THC, amphetamines, methamphetamine, mescaline, psilocybin, heroin, babtiturates, or methaqualone. Generally speaking, drugs alleged to be THC turned out to be phencyclidine (PCP) in 99% of the cases. Drugs claiming to be either mescaline of psilocybin were usually LSD and/or PCP. Alleged amphetamines usually turned to be some other type of CNS stimulant (e.g., caffeine, ephedrine, phenylephrine). Alleged barbiturates adn methanqualone were usually some other type of CNS depressant (E.g., antihistamines, Librium^{R}, Valium^{R}). In contrast, marijuana, hashish, LSD, and cocaine were most often correctly represented.

DRUG PURITY. This refers to the degree to which a drug is free of impurities or contaminants. Often during the manufacturing process, the drug product will become contaminated with chemical impurities. If these impurities are not removed they themselves can cause adverse effects to the drug user. For example, acetic acid is used in the chemical reaction converting morphine to heroin. If the residual acetic acid or its by-products are not washed or filtered out of the heroin, they can produce considerable pain and irritation when the heroin is injected.

Adulterants

Agents present in addition to or in place of the principle drug in question, are considered inert (inactive), or active. Active agents are capable of producing effects of their own. In many instances, the adverse effects experienced by the drug user are attributable to the adulterating agent and not the principle drug. Thus, in assessing adverse drug reactions, one must consider the possibility of an adulterant as the causative agent. Almost any type of substance can be considered as an adulterant; the following examples are the main common types:

any type of substance can be considered as an adulterant; the following examples are the main common types.

SUGARS (e.g. lactose, inositol, mannitol). These agents are usually inert. They are often used as fillers to "cut" other drugs in order to increase the bulk amount, yet decrease the actual amount of principle drug per unit.

CNS STIMULANTS (e.g. caffeine, strychnine, ephedrine, phenylephrine, propanolamine). These agents are active CNS stimulants, which are often used in addition to or combined, in place of amphetamines. Stimulant effects on the cardiovascular system, as well as the CNS can result in restlessness, dizziness, insomnia and increased heart rate and blood pressure. Withdrawal from long-term use of these agents can produce mental depression and somnolence. In addition, strychnine is a potent convulsion producing agent.

LOCAL ANESTHETICS (e.g. benzocaine, procaine, lidocaine, tetracaine). These agents are active and are often used together with or in place of cocaine. In sufficient doses, they produce CNS stimulant effects and in high doses they can produce convulsions and cardiac arrest. Benzocaine differs from other local anesthetics in that it is insoluble, (will not dissolve in solution). Thus, if it is injected I.V., it can cause an obstruction of blood vessels (embolus), resulting in organ damage. These agents, benzocaine in particular, are also known to cause hypersensitivity (allergic), reactions.

BELLA DONNA ALKALOIDS (e.g. atropine, scopolamine). In sufficient doses, these agents are active hallucinogens and are often combined with other hallucinogenic drugs, such as LSD and PCP. Hallucinations produced by these agents tend to be quite vivid and often frightening. Adulterating hallucinogens with alkaloids of this type can complicate the clinical picture surrounding hallucinogen intoxication (OD). These agents can potentiate both the hyperthermic effects of hallucinogens, as well as the hypotensive effects of the anti-psychotic tranquilizers (e.g. Thorazine®), often used to treat hallucinogen ODs. This potentiation can result in extreme elevations in body temperature and severe decreases in blood pressure (shock). In addition, several rather unpleasant effects, such as palpitations, dry mouth, increased body temperature, blurred vision, constipation, and urinary retention, are also produced.

ANTI-HISTAMINES (e.g. Benadryl, methapyrilene). These agents are active CNS depressants and are often combined together with other sedative-hypnotics or used in place of sedative-hypnotics, such as barbiturates and methaqualone. These agents can interact synergistically with other sedative-hypnotics, (including alcohol), to

produce drowsiness, sedation, sleep and, in high doses, respiratory depression and coma. In addition to these CNS depressant effects, anti-histamines can produce the same unpleasant effects as the belladonna alkaloids, such as dry mouth, blurred vision, palpitations, constipation and urinary retention.

QUININE. This agent is often used as a filler to "cut" different drugs, such as heroin. It has a bitter taste and physical appearance much like that of heroin. Quinine contributes to the heroin "rush" while its bitter taste makes it impossible to judge the concentration of heroin contained in the mixture. Although it is commonly thought to be inert, quinine produces a characteristic pattern of toxic symptoms, manifested by ringing of the ears (tinnitus), impaired hearing, visual disturbances, dizziness, headache, nausea/vomiting, and diarrhea - collectively termed "cinchonism". In addition to these relatively unpleasant side effects, quinine can be extremely irritating to body tissues when it is administered. In high doses, it can cause cardiac depression/arrest and severe decreases in blood pressure, especially when injected I.V. Hypersensitivity (allergic), reactions, including anaphylactic shock, are known to occur in certain individuals exposed to quinine. This hypersensitivity (anaphylactoid), reaction to quinine is thought to be responsible for many of the sudden death occurrences in heroin users. The sudden death occurrence, following administration of heroin, (termed Syndrome X), which has been attributed to heroin OD in the past, may actually result from an allergic reaction.

SALICYLATES (e.g. aspirin, salicylic acid). Like quinine, these active agents are commonly used as fillers to "cut" various kinds of drugs and are mistakenly thought to be inert. Salicylates produce a characteristic pattern of toxic effects, manifested by tinnitus, impaired hearing, nausea/vomiting, diarrhea, hallucinations, and severe acid-base upset, which can result in death. These toxic effects are collectively termed "salicylism". Allergic reactions, including anaphylactic shock, can also result from the use of salicylates in sensitive individuals. In addition, the acidic nature of the salicylates can cause considerable local irritation when they are injected.

PHENCYCLIDINE (PCP). This is a hallucinogenic agent often used alone or together with LSD in place of THC, mescaline, psilocybin, and other of the more exotic psychotomimetics. Although the drug is marketed as an animal tranquilizer (Sernylan^{R}), its effects on humans are paradoxical. These effects are manifested by schizophrenic-like symptoms, anxiety, delusions, hallucinations, and in high doses it can produce convulsions. Bizzare behavior and panic/fear reactions are commonly noted. In one study, only three out of fifty-five patients given PCP experienced any euphoria or other pleasant effects. Compared to the hallucinogenic

effects of LSD or mescaline, the effects of PCP tend to be unpleasant and frightening.

MISCELLANEOUS AGENTS (e.g. corn starch, reserpine, acetaminophen, vitamins, baking soda). As mentioned before, almost any substance can be used as an adulterant to either mimic or facilitate the effects of a principle drug or to act merely as a filler. Many adulterating agents are erroneously thought to be inert, yet produce significant effects of their own.

The treatment of OD or adverse reactions can be complicated by the presence of an adulterant. The extraneous agent may be the single cause of the adverse effect or it may be contributing to the overall toxicity of the principle drug. In either case, antidotal therapy is hampered by the lack of characteristic symptoms and not knowing what drug is causing the symptoms. For example, treating an apparent heroin OD with a narcotic antagonist (e.g. Narcan^{R}) would be inappropriate, if the primary symptoms were due to the quinine adulterant causing an allergic reaction.

Exercise 11

Complete the following exercise. The correct answers are provided in the appendix.

1. What is meant by the integrity of a drug?

2. What are adulterants?

3. What is meant by "cutting" a drug?

4. Local anesthetics are most commonly used as adulterants in associating with what principle durg?

5. Anti-histamines have effects similar to what drug(s)?

6. What is "salicylism"?

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APPENDIX

ANSWERS TO EXERCISES

Exercise 1

1. Therapeutic dose refers to the amount of drug needed to produce a desired (primaty) effects.

2. Potency refers to the amount (dose) of drug needed to produce a particular effect, whereas efficany is the miximal effectiveness a drug is capable of producing.

3. Psychological dependence provides the mantal drive for continued drug use. Tolerance provides a means of increasing the dose level of a drug in the body needed to produce an effect, thus stimulating adaptation. Physical dependence results from the physical adaptation stimulated by tolerance. The occurance of withdrawal indicates the presence of physical dependence once drug use is stopped.

4. a. Sedative-hypnotics.

   b. Stimulants.

   c. Hallucinogens.

   d. Narcotics.

   e. Relaxants/Euphoriants.

Exercise 2

1. a. Drugs act on existing structures and functions to produce effects. Drugs create nothing in the individual that does not already exist.

   b. No drug produces only a single effect. Whether an effect is good or bad depends on the conditions under which the drug is used and on the particular effect wanted from the drug.

   c. Dose is the main determinant of a drug's effect. The drug effect depends on how it's used and primarily on the dose used.

   d. Response to a drug varies within a population due to variation between living things.

2. a. Dose-time-response relations.

   b. Dose-percent-response relations.

   c. Pharmacodynamics.

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3. A response that varies as the dose changes.

4. Absorption, distribution, metabolism and excretion.

Exercise 3

1. a. Oral.

   b. Inhalation.

   c. Injection.

2. a liver.

   b. Kidney.

3. Intravenous (I.V.) injection route of administration.

APPENDIX

ANSWERS TO EXERCISES

Exercise 4

1. CNS depression.

2. Dose, time course, and biologic variation.

2. Specific narcotic antagonists; e.g., Nalline^{R}, Narcan^{R}.

Exercise 5

1. Sedative-hypnotic tolerance does not develop to the lethal symptoms.

2. Both withdrawal syndromes exhibit symptoms indicative of increased CNS excitability. Sedative-hypnotic withdrawal is much more dangerous and medical treatment is often required.

3. Symptomatic treatment to maintain vital functions.

Exercise 6

1. Sedative-hypnotics.

2. Moderate degree of psychological dependence; little, if any, physical dependence.

3. a. Physical injury.
   b. Organ damage.
   c. Cryogenic/allergic reactions.
   d. Sudden death.

Exercise 7

1. Anti-psychotic tranquilizers and sedative-hypnotics.

2. The symptoms of stimulant withdrawal are indicative of decreased CNS activity; whereas, narcotic or sedative-hypnotic withdrawal symptoms are indicative of increased CNS excitability.

3. It mimics the paranoid schizophrenic state, it can occur during acute or chronic stimulant use, and it is usually reversible upon discontinuation of the drug.

Exercise 8

1. Induced changes in CNS perceptions.
2. "Talking down," limiting sensory stimuli, and use of sedative-hypnotics.
3. Pseudo-hallucinations.

Exercise 9

1. The Δ^9 THC content.
2. No characteristic withdrawal syndrome has been established for the relaxant/euphoriant drugs.
3. a. Chronic psychological

   b. Social deterioration.

   c. Physical injury.

   d. Psychotic reactions.

   e. Criminal p-osecution.

   f. Unknown, long-term effects.

Exercise 10

1. Stimulant drugs.
2. a. Nicotine.

   b. Carbon monoxide.

   c. Tars.
3. Heartbeat disturbances and increased blood pressure.

Exercise 11

1. a. Dose/strength.

   b. Composition.

   c. Purity.

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2. Any agent(s), inert or active, which are used together with or in place of the principle or alleged drug.

3. Adding a filler agent (inert or active) to a principle drug in order to increase the bulk amount.

4. Cocaine.

5. CNS depressant effects similar to the sedative-hypnotics unpleasant side effects similar to the belladonna alkaloids.

6. A term applied collectively to the characteristic pattern of toxic effects produced by the salicylate drugs.

Pharmacology Review

Pharmacologic Action:	CNS Depression	CNS Stimulation	Change in CNS Perceptions
Drug Class			
Narcotic Opiate	X		
Sedative-Hypnotic	X		
Inhalant	X		
Stimulant		X	
Hallucinogen			X
Relaxant/Euphoriant			X
Nicotine		X	

Dependence Cycle:	Psychological Dependence	Tolerance Phenomenon	Physical Dependence	Withdrawal Syndrome
Drug Class				
Narcotic Opiate	X	X	X	X
Sedative-Hypnotic	X	X	X	X
Inhalant	X	X	X	X
Stimulant	X	X	X	X
Hallucinogen	X	X		
Relaxant/Euphoriant	X			
Nicotine	X	X	X	X

Stage of Use:	Initial/Average Dose	Acute Toxicity	Chronic Use
Characteristics			
Single dose use	X	X	
Short-term use	X	X	
Long-term use			X
Therapeutic doses	X		X
Low doses	X		
Excessive doses		X	
Toxic doses		X	
Overdose		X	
Progressively higher doses			X

Withdrawal Symptoms indicative of:	Depression	Stimulation
Depressant Drugs		
Narcotic Opiates		X
Sedative-Hypnotics		X

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Withdrawal Symptoms indicative of:	Depression	Stimulation
Depressant Drugs		
Inhalants		X
Stimulant Drugs	X	
Nicotine	X	

Suggestions:

- Know at least 3 representative examples from each drug class.
- Be able to distinguish the symptoms occuring at different stages of use.
- Know whether symptoms are either dpressant or stimulatory in nature.

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Social Actions Training Branch
Lackland Air Force Base, Texas

LP B3-II-1 (1)
1 August 1978

Score_____%

DRUG PHARMACOLOGY QUIZ

Rank_____ Name_____ Group_____
Last First MI

Circle Correct Answer

CO #

3a. 1. The term habituation refers to:

a. Tolerance

b. Psychological dependence

c. Physical dependence

d. Cross-tolerance

2. A drug's effect depends primarily on its:

a. Variation

b. Tolerance

c. Dose

d. Dependence

3. A route of elimination is best exemplified by:

a. Skin popping

b. Injection

c. I.M.

d. Liver

4. Narcotics are best described as Central Nervous System:

a. Stimulants

b. Depressants

Supersedes Q B-II-3-31, 20 March 1978

Designed for ATC Course Use
No Not Use on the Job.

Attachment 1

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c. Hallucinogens

d. Psychotomimetics

5. Acute toxicity involving a sedative-hypnotic drug is likely to involve:

a. Increased respiration

b. Consciousness

c. Addiction

d. Decreased blood pressure

6. The primary pharmacologic action of the inhalants best resembles, which type of drug(s)?

a. Nicotine

b. Sedative-hypnotics

c. Hallucinogens

d. Hashish

7. Which one of the following is true with respect to the initial/average dose stage of the stimulant drugs?

a. Anticonvolusant

b. Increase appetite

c. Sedation

d. Heartbeat disturbances

8. Chronic use of tetrahydrocannbinol may result in:

a. Physiological Dependence

b. Reverse tolerance

c. Motivation

d. Addiction

9. What action does LSD have in common with the barbiturates, narcotics and alcohol?

   a. Addiction

   b. Cross-tolerance

   c. CNS depression

   d. Tolerance

10. Nicotine has the potential for producing:

   a. Psychological dependence

   b. Tolerance

   c. Withdrawal symptoms

   d. All of the above

11. Caffeine, Strychnine, ephedrine are commonly used together with or in place of which kind of drugs?

   a. Heroin

   b. Barbiturates

   c. Marijuana

   d. Amphetamines

PLAN OF INSTRUCTION/LESSON PLAN PART I

NAME OF INSTRUCTOR	COURSE TITLE
	Drug and Alcohol Abuse Control

BLOCK NUMBER	BLOCK TITLE
II	Basic Skills and Knowledges

1 COURSE CONTENT	2 TIME

2. Mental Health Terminology

a. Identify terminology used to describe mental illness and disorders that occur during personality development.

SUPPORT MATERIALS AND GUIDANCE

Student Instructional Materials
SW B-II-2-f, Mental Health Terminology

Audio-Visual Aids
35mm Slides, Mental Health Terminology

Training Methods
Lecture
Group Discussion

Instructional Guidance
Explain criteria used to define mental illness in our society. Identify the categories of mental illness and give examples. Discuss personality labels and the inappropriateness of their use. Cover the major symptoms of pathology, and stress the referral of clients who exhibit them.

SUPERVISOR APPROVAL OF LESSON PLAN (PART II)

SIGNATURE AND DATE	SIGNATURE AND DATE

PART II - TEACHING GUIDE

INTRODUCTION (2 Minutes)

ATTENTION

Mental disorders are a serious problem. Current statistics indicate:

a. One in twenty people today spend time in mental hospitals.
b. Ten percent of the population has problems in living which interfere with daily efficiency. Five percent are hospitalized.
c. About one-half of the hospital beds in the U.S. are occupied by persons suffering from mental disorders.

OVERVIEW

1. Read the lesson objectives to the class.

2. Develop the lesson chronology.

a. Define mental illness.
b. Define and give examples of major mental illness categories.
c. Problems with labels.
d. Identify major symptoms of pathology.

MOTIVATION

Statistically, there is an excellent chance you will use this information with your family or friends. Surely, it will help you understand official communication in this area on the job.

BODY (1 Hour 55 Minutes)

PRESENTATION

3a CRITERION OBJECTIVE: Identify The four different criteria used to

define mental illness.

1. Explain the statistical occurrence approach. How often and to what degree does the behavior occur in the general population? This is the "Normal" versus "Abnormal" approach.

2. Explain societal standards as criteria for definition. To what degree is the behavior condemned by society at large? The more condemned a behavior, the more abnormal the behavior is considered to be.

3. Explain the use of numbers seeking treatment or the numbers referred for treatment as criteria for definition. If many people need treatment for a set of behaviors, it is considered to be a "problem" rather than a "disease" or "illness."

4. Discuss degree of impairment as a criterion for definition. To what degree does the behavior interfere with the individual's ability to function; i.e., have a family, hold a job, stay alive, etc.

5. State the criteria for a normal personality IAW Maslow and Mittelmann. The normal/healthy person should have the following: Adequate feelings of security; reasonable degree of self-evaluation (insight); realistic life goals; effective contact with reality; integration and consistency of personality; ability to learn from experience; adequate spontaniety; appropriate emotionality; ability to satisfy the requirements of the group, coupled with some degree of emancipation from the group (ability to get along coupled with independence); and adequate but unexaggerated bodily desires, with the ability to gratify them in an appropriate fashion. To be normal, a person may not be

ideal in all of these areas, but to be normal the person should be somewhat successful in most of these areas. If the person is deficient in too many, or very deficient in one or two of these areas, the person is usually considered to be abnormal.

APPLICATION/EVALUATION

What is the difference between the statistical occurrence approach and the number seeking treatment method of defining mental illness?

PRESENTATION

3b. CRITERION OBJECTIVE: Identify the six major categories of mental illness and discription of each.

1. Describe organic brain syndrome - disorders caused by or associated with impairment of brain tissue function.

a. Symptoms include:
(1) Impairment of orientation. (Time/date, person, place.)
(2) Impairment of memory.
(3) Impairment of all intellectual functions such as comprehension, calculation, knowledge, learning, etc.
(4) Impairment of judgement.
(5) Instability and shallowness of affect. (e.g. quickly change from smiling to tears.)

b. Distinguish between acute and chronic,
(1) Acute - temporary and reversible.
(2) Chronic - permanent and persistent.

c. Examples of Organic Brain Syndrome:
(1) Delirium Tremes -

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A variety of acute brain syndrome characterized by delirium coarse tremors, and frightening visual hallucinations.

(2) Alcohol Paranoid State - a paranoid state which develops in chronic alcoholics, generally male, and is characterized by excessive jealousy and delusions of infidelity by the spouse.

(3) Korsakov's Psychosis - A variety of chronic brain syndrome associated with long standing alcohol abuse and characterized by memory impairment, disorientation, peripheral neuropathy, and particularly by filling in of memory gaps with false and often irrelevant details.

2. Describe Psychosis - persons are described as psychotic when their mental functioning is sufficiently impaired to interfere grossly with their capacity to meet the ordinary demands of life.

a. Symptoms include:
(1) Delusions - false beliefs.
(2) Hallucinations.
(3) Alterations of mood.
(4) Weak contact with reality.

b. Distinguish between Organic and Functional.
(1) Organic - psychosis associated with organic brain pathology.
(2) Functional - psychosis precipitated primarily by psychological stress, having no demonstratible organic basis of etiology

c. Examples of psychosis:
(1) Schizophrenia - A group of psychotic reactions in which there are fundamental disturbances in reality relationships and in emotional and

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intellectual processes. These reactions are primarily thought disorders.

(2) Affective Disorders - These behavior patterns are characterized by a single disorder of mood, either extreme depression or elation, that dominates the mental life of the person and is responsible for whatever loss of contact the person has with his/her environment.

(3) Paranoid states - these are psychotic disorders in which a delusion, generally persecutory or grandoise, is the essential abnormality. Disturbances in mood, behavior and thinking (including hallucinations) are derived from this delusion.

3. Describe neurosis - manifest neither gross distortion or misinterpretation of external reality, nor gross personality disorganization. Neurotics are people who have failed to develop mature emotional, interpersonal, and motivational patterns.

a. Symptoms include:

(1) Inadequacy and low stress.

(2) Anxiety, fearfulness and unreasonable doubts.

(3) Egocentricity (preoccupied with self) and distrubed interpersonal relationships.

(4) Persistent behavior patterns which do not lead to any sense of personal satisfaction.

(5) Lack of insight and rigidity.

(6) Disatisfaction and unhappiness and loneliness, pessimism (rarely experiences inner joy.)

(7) Psychological and physiological ills and complaints.

b. Examples are:

(1) Anxiety neurosis - Anxiety neurosis is characterized by anxious

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over-concern extending to panic and frequently associated with physical ilness.

(2) Phobic neurosis - characterized by intense fear of an object or situation which the person consciously recognizes as no real danger to him/her.

(3) Obsessive-compulsive - characterized by the persisitent intrusion of irrational thoughts and impulses that the person is unable to stop

(4) Depressive neurosis - manifested by an excessive reaction of depression due to an internal conflict or to an identifiable event such as the loss of a love object or cherished possession.

4. Describe personality disorder - This group of disorders is characterized by deeply ingrained maladaptive patterns of behavior that are perceptibly different in quality from psychotic and neurotic symptoms. Generally these are life long patterns, often recognizable by the time of adoles cence or earlier.

a. Examples are:

(1) Paranoid personality - characterized by hypersensitivity, rigidity, unwarranted suspicion, jealousy, envy, excessive self importance, and a tendency to blame others and acribe evil motives to them.

(2) Schizoid personality - manifested by shyness, over-sensitivity seclusiveness, avoidance of close or competitive relationships, and often ego-centricity.

(3) Explosive personality - characterized by gross outbursts of rage or verbal or physical aggressiveness. These outbursts are strikingly different from the person's usual behavior, and he/she may be regretful and repentant for them.

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(4) Obsessive compulsive personality - characterized by excessive concern with conformity and adherence to standards of conscience. Consequently, individuals in this group may be rigid, over-inhibited, over-conscientious, over-dutiful, and unable to relax easily.

(5) Antisocial personality - characterized by basically unsocialized behavior patterns which bring the person repeatedly into conflict with society.

(6) Passive-aggressive personality - characterized by both passivity and aggressiveness. The aggressiveness may be expressed passively by obstructionism, pouting, procrastination, intentional inefficiency, or stubborness.

(7) Inadequate personality - characterized by ineffectual responses to emotional, social, intellectual and physical demands. While the person seems neither physically nor mentally deficient, he/she does manifest inadaptability, ineptness, poor judgment, social instability, and lack of physical and emotional stamina.

(8) Hysterical Personality - These behavior patterns are characterized by excitability, emotional instability, over-reactivity, and self-dramatization. This self-dramatization is always attention-seeking and often seductive, whether or not the person is aware of its purpose. These personalities are also immature, self-centered, often vain, and usually dependent on others.

5. Describe transient-situational disorder - acute symptom response to an overwhelming situation in basically stable personality.

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a. Symptoms are;

(1) Can show any type of symptoms.

(2) Symptoms subside when the stress diminishes.

b. Examples are:

(1) Gross stress reaction - reactions to combat or to civilian catastrophes.

(a) Shell shock - caused by general combat situations with its physical fatigue, the ever present threat of death or mutilation, and severe psychological shocks. Symptoms include: Dejection, weariness, hypersensitivity, sleep disturbances, and tremors.

(b) Civilian catastrophes - usually have three stages:

1 Shock stage - the victim is stunned, dazed and apathetic.

2 Suggestible stage - the individual tends to be passive, suggestible, and willing to take directions from rescue workers or others less affected.

3 Recovery stage - individual gradually regains his/her psychological equilibrium, often with the help of mild supportive psychotherapy at a hospital or other aid center.

(2) Adjustment reactions - may be manifested as reactions to infancy, adolescence, adult situations, or reactions of later life.

6. Psychophysiologic disorders - characterized by physical symptoms that are caused by emotional factors and involve a single organ system,

usually under autonomic nervous system innervation.

a. Characteristics of changes -

(1) Changes involved are those that normally accompany certain emotional states, but in these disorders the changes are more intense and sustained.

(2) individual may not be consciously aware of his/her emotional state.

b. Examples are:

(1) Psychophysiologic musculosketal - applies to musculosketal disorders such as backache, muscle cramps and pain in muscles, and tension headaches in which emotional factors play a causative role.

(2) Psychophysiologic cardiovascular - applies to cardiovascular disorders such as severe rapid heartbeat, hypertension, vasuclar spasms, and migraine in which emotional factors play a causative role.

(3) Psychophysiologic gastrointestinal - applies to specific types of gastronintestinal disorders such as peptic ulcer, chronic gastritis, ulcerative of mucous colitis, constipation, hyperactiviy, pylorospasm, "heartburn" and "irritable colon" in which emotional factors play a causative role.

APPLICATION/EVALUATION

1. What are three types of organic brain syndrome that may be associated with alcoholism?

2. What is the difference between a psychosis and a neurosis?

3. What is a personality disorder?

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4. Name two examples of transient stress disorders.

PRESENTATION

3c. CRITERION OBJECTIVE: Identify the four major problems with using labels when describing a person's personality.

1. Explain that labels are used as entities. Labels are used to describe types of behavior not the whole person - since people are more than just one type of behavior, people are more than a label may imply.

2. Explain that labels are imprecise. Undifferentiated schizophrenia refers to a group of schizophrenia disorders which cannot be classified as a specific type of schizophrenia - The people in this category may haver very little in common. Labels cause miscommunication because they are imprecise.

3. Explain that labels are difficult to change. Once you are labelled, you are often discriminated against.

4. Explain that people react to labels rather than the person. Since people are more than the labels imply, this can be a big mistake.

APPLICATION/EVALUATION

1. What is one of the problems associated with labeling?

2. How have you seen problems in this area at your home base?

PRESENTATION

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3d. CRITERION OBJECTIVE: Identify the ten major symptoms of pathology.

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These symptoms may indicate serious mental health problems, but also may indicate physical health or other problems.

1. Explain inability to sleep - early-morning awakening.

2. Explain weight loss (food doesn't taste good; not hungry).

3. Explain complaint of over-sleep (12 or more hours a day).

4. Explain deterioration of appearance and cleanliness (marked).

5. Explain hyperactivity (compulsive pacing, etc.).

6. Explain inappropriate affect; i.e., "gallows" laughter.

7. Explain blunted affect.

8. Explain hallucinations (auditory and/or visual).

9. Explain suicide or suicide-like statements.

10. Explain uncontrollable weeping or rage.

11. Generally speaking, when these are seen by social actions personnel, the client should be referred to the mental health clinic or a physician for an evaluation.

CONCLUSION (3 Minutes)

SUMMARY

1. Four ways of defining mental illness.

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2. Definition of the major mental illness categories.

3. Four major problems with using labels.

4. Ten major symptoms of pathology.

REMOTIVATION

This gives you most of the information which would be presented in an abnormal psychology class without the "busy work." During your tenure in Social Actions, you may encounter some people with severe problems. Be watchful and refer them to profersionals.

ASSIGNMENT

Give Complementary Technical Training assignment, when appropriate.

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STUDY GUIDE AND WORKBOOK

L3ALR73430B/L30LR7361B/L30ZR7364B-II-2-1

Technical Training

Drug and Alcohol Abuse Control

Basic Skills and Knowledges

MENTAL HEALTH TERMINOLOGY

9 June 1978

HEADQUARTERS 3250 TECHNICAL TRAINING WING (ATC)
(USAF Technical Training School)
Lackland Air Force Base, Texas 78236

DESIGNED FOR ATC COURSE USE. DO NOT USE ON THE JOB.

ATC FORM 214 (JAN 78) OBSOLETES ATC FORMS 214, MAY 69, 522, NOV 63 AND 523, MAY 71. STANDARD COVERSHEET

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SOCIAL ACTIONS TRAINING BRANCH
Lackland Air Force Base, Texas

SW L3ALR73430B/L30LR7361B/L30ZR7364B-II-2-1
9 June 1978

Basic Skills and Knowledges
MENTAL HEALTH TERMINOLOGY

OBJECTIVE

Identify terminology used to describe mental illness and disorders that occur during personality development.

INTRODUCTION

Upon completion of this unit of instruction, you will be able to identify four different criteria used to define mental illness, six major categories of mental illness and a description of each, four major problems with using labels when describing a person's personality, and 10 major symptoms of pathology (mental illness). You will also be given an opportunity to identify ego defense mechanisms used by all of us to protect our self image and reduce or prevent anxiety.

INFORMATION

STATISTICAL OCCURRENCE APPROACH

The statistical occurrence approach is the graphic or mathematical approach to the question of what is normal or abnormal behavior. "Normal" people are considered to be those whose behavior falls within one or two standard deviations of the average behavior. Approximately 90 to 95 percent of the people in a society are considered to be "normal," because these persons exhibit behavior which is close to the norm (close to the average behavior). The question used to define mental illness in this approach is, "How often and to what degree does a behavior occur in the general population?" A person's behavior is then compared to the average or "normal" behavior, and if that behavior differs too greatly from the "norm," then it is considered to be abnormal behavior. Statistical methods are used to measure intelligence but the statistical method encounters much difficulty when trying to measure such complex characteristics of the total personality.

SOCIETAL STANDARDS

From this view point, the behavior and attitudes of an individual are considered as either normal or abnormal according to the social milieu (environment) in which the person lives. The more a behavior is condemned in a society, the more abnormal the behavior is considered to be. This definition is concerned with the taboos or things people should not do in order to be socially acceptable. Throughout our history, people that have accomplished

Supersedes SW 3ALR73430B/30LR7361B/30ZR7364B-II-3-6, 1 January 1978 & HO B-II-3-5, April 1978

tasks that are out of the ordinary or that have demonstrated behavior not previously shown, have been looked upon as "different" or mentally ill. Writers, inventors, artists, and certain innovators were considered abnormal. Gallileo, di Vinci, Columbus, Jesus, Poe, Shakespeare, and Freud are just a few examples. The culture/society in which a person lives can be very intolerant of behaviors which depart from the norm. Some societies are more strict about what is considered normal than others. Reasonable latitude may be allowed for individual expression, but in most societies, radical digressions which create turmoil in the person and in people around that person are usually considered to be signs of abnormal personality. Our tolerance of differing behaviors in American society is broadening. First, in a world society in which different cultures which used to be isolated from each other, now intermingling is a common occurrence. As a result, we are coming to realize that customs and attitudes felt to be normal in one culture may be called abnormal in another. Because of the mingling of cultures, broader ranges of behaviors are now accepted. Second, as our culture becomes more pluralistic (allowing a broader range of beliefs and behaviors) what was unacceptable social behavior a generation ago, may now be accepted as normal in today's society. Although our society does accept a larger span of behavior than it did a century ago, there are still types of behavior which are considered abnormal. People who exhibit behavior which is too radical and disturbing to the people around them are likely to be locked up.

NUMBER SEEKING OR REFERRED TO TREATMENT

Another way of defining mental illness is the number seeking treatment or referred for treatment. If a large number of people sought treatment for a condition, we would tend to call the condition something other than mental illness. For instance, people who are encountering difficulty with their marriage relationship are said to have "marital problems" rather than to be mentally ill. This is because such a large portion of our culture has difficulty in the marital relationship. On the other hand, if only a few people seek treatment for a condition, then we tend to call it mental illness. A person who exposes his/her gentials is said to be mentally ill unless he/she does it in mass or as part of a fad. In the latter case, exposing one's self is called "flashing."

DEGREE OF IMPAIRMENT

The final way we define mental illness is in terms of the degree of impairment. The degree of impairment is the degree to which a behavior or personality problem interferes with the person's ability to function in his/her life. For example, the person who is unable to hold a job, maintain friendships, a family, or even remain alive is usually considered to be mentally ill. People who cannot cope with life's day-to-day problems must be given special care or hospitalization, and are therefore considered abnormal.

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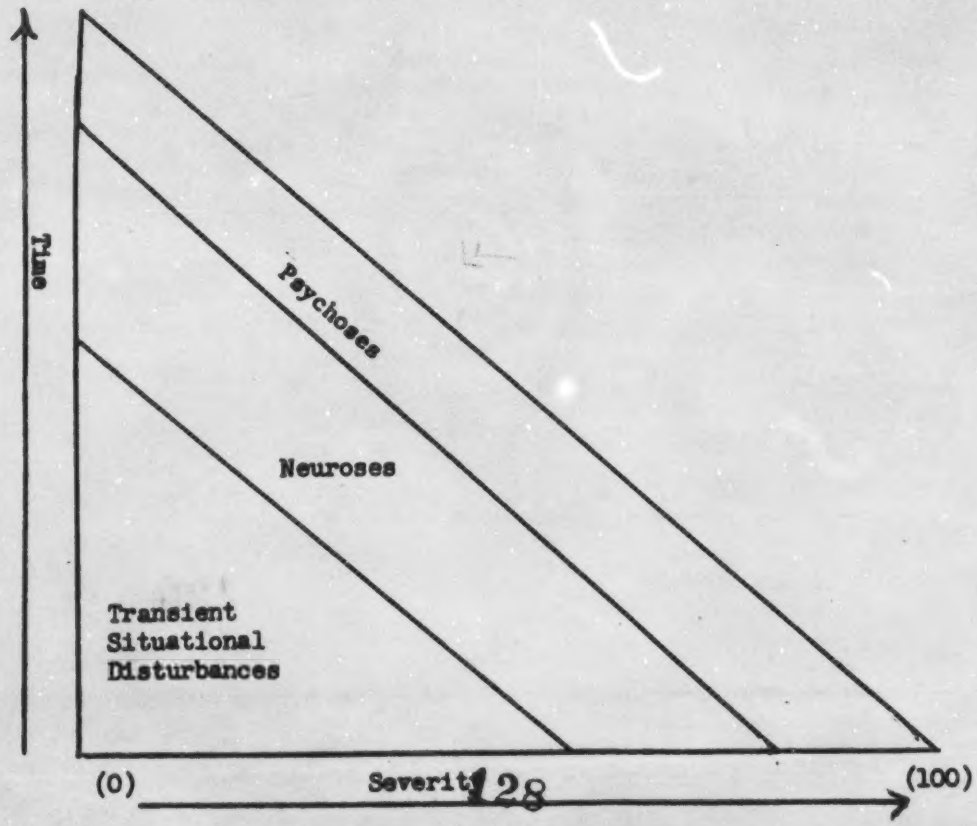
CRITERIA FOR A NORMAL PERSONALITY

Although we have discussed methods of defining mental illness and abnormal behavior, it is good to contrast these criteria with the criteria for a normal personality. A.H. Maslow and B. Mittelmann present a description of a healthy and normally functioning person in, *Principles of Abnormal Psychology*, New York, Harper, 1951, pp. 14-15. A list of criteria which summarizes their description include the following: adequate feelings of security; reasonable degree of self-evaluation (insight); realistic life goals, effective contact with reality; integration and consistency of personality; ability to learn from experience; adequate spontaneity; appropriate emotionality; ability to satisfy the requirements of the group, coupled with some degree of emancipation from the group (ability to get along coupled with independence); and adequate but unexaggerated bodily desires, with the ability to gratify them in an appropriate fashion. To be normal, a person may not be ideal in all of these areas, but to be normal the person should be somewhat successful in most of these areas. If the person is deficient in too many, or very deficient in one or two of these areas, the person is usually considered to be abnormal.

TRANSIENT SITUATIONAL DISTURBANCE

The Diagnostic and Statistical Manual, second edition, of the American Psychiatric Association (DSM-II) points out that, this major category is reserved for transient disorders (including those of psychotic proportions) that occur in individuals who have no apparent underlying mental disorders. This disorder represents reaction to overwhelming environmental stress.



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*Stress is a class of stimuli which threatens the individual in some manner and produces disturbances in behavior. The stress is not the disturbance itself but the strain and pressure leading to the behavioral disturbance. Behavioral disturbances may be caused by organic conditions or be the result of psychological stress!

ORGANIC STRESS

1. Illness & injury
2. Childbirth
3. Abortion
4. Sterilization (vasectomy/hysterectomy/tubiligation)
5. Pregnancy
6. Menopause (female/male)

PSYCHOLOGICAL STRESS

The psychological stresses that impact upon a person are defined by that person (One man's pleasure is anothers poison). The crisis that results from stress measure upon the values, beliefs, perceptions, and prior experiences of the individual.

Due in large measure to research conducted within the past ten years by Drs. Holmes and Rahe. They have discovered that many events within a person's life are determined by the amount of stress under which he is functioning, including such diverse events as major medical problems, suseptability to colds and flu, and serious traffic accidents. This is perhaps more easily understood when one considers that 70% of all medical and surgical treatments are administered to only 30% of the population.

Each of us are subjected to stress daily. What scientific investigation has determined is how much different life events contribute to the amount of stress we are influenced by. The following list, developed by Holmes and Rahe, provides the life events and the value for each in terms of stress:

Life Event	Mean Value
Death of spouse	100
Divorce	73
Marital separation	65
Jail term	63
Death of close family member	63
Personal injury or illness	53
Marriage	50
Fired at work	47
Marital reconciliation	45
Retirement	45
Change in health of family member	44
Pregnancy	40
Sexual difficulties	39
Gain of new family member (birth, adoption, oldster moving)	39
Business readjustment (merger, reorganization, bankruptcy)	39

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Change in financial state (better or worse than usual)	38
Death of close friend	37
Change to different line of work	36
Change in number of arguments with spouse (more or less)	35
Mortgage over $10,000 (buying home or business)	31
Foreclosure of mortgage or loan	30
Change in responsibilities at work (promotion, demotion, or lateral transfer)	29
Son or daughter leaving home	29
Trouble with in-laws	29
Outstanding personal achievement	28
Wife begins or stops work	26
Begin or end school	26
Change in living conditions (e.g., building a new home, remodeling, deterioration)	25
Revision of personal habits (dress, manners, associations)	24
Trouble with boss	23
Change in work hours or conditions	20
Change in residence	20
Change in schools	20
Change in recreation	19
Change in church activities	19
Change in social activities (e.g., clubs, dancing, movies, visiting)	18
Mortgage or loan less than $10,000 (e.g., purchasing a car, tv, or freezer)	17
Change in sleeping habits (a lot more or a lot less)	16
Change in number of family get-togethers	15
Change in eating habits (more/less, type, surroundings)	15
Vacation	13
Christmas	12
Minor violations of the law (e.g., traffic tickets, etc)	11

The reporting period is 24 months, that is, the number of times these events have occurred to the person within the last 24 months. These are added together for the composite score. Holmes, Rahe, and their colleagues have discovered that should one accumulate 150 points on the scale within a period of two years, there is a 33% probability that one will contact an illness or suffer an accident. When 300 points are accumulated, the probability soars to 66%. At 450 points the probability is almost certain, in the 90% range.

What is apparent from the above data is that even "good" events can produce stress for the individual. Also, even "normal" people, as contrasted to "neurotic" persons are susceptible to the effects of stress and associated psychosomatic illness (illnesses caused by the inability of the mind and body to deal with stress).

1. Disasters (natural/man made)
2. War (shell shock/battle fatigue/POW)

Civilian catastrophes usually have three states: Shock stage -- the victim is stunned, dazed and apathetic. Suggestible or recoil stage -- the individual tends to be passive, suggestible, and willing to take directions from rescue workers or other less affected personnel. Recovery stage -- individual gradually regains his/her psychological equilibrium, often with help of mild supportive psychotherapy at a hospital or other aid center.

Identifying Behaviors

An individual suffering from a Transient Situational Disturbance may display any of several psychological behaviors, however, the following are the most commonly seen.

a. Anxiety with a clear, identifiable cause.
b. Confusion -- a sense of bewilderment and an inability to recognize alternative courses of action.
c. A loss of self-esteem -- person feels unworthy or guilt ridden, particularly when they have survived and a loved one has not.
d. Specific fears -- person is afraid to repeat behaviors that preceded the disaster.
e. Apathy -- person feels worn out, tired, fatigued without working.
f. Sleep disturbance -- person suffers from nightmares. Sleep loss/or the need for excessive sleep.
g. Appetite disturbance -- person may cease eating or begin overeating.

PERSONALITY DISORDERS

The DSM-II defines this group of disorders as ingrained maladaptive patterns of behavior that are different in quality from psychotic and neurotic symptoms. Generally, these are life-long patterns, often recognizable by the time of adolescence or earlier.

The key phrase is "deeply ingrained maladaptive patterns of behavior." In attempting to meet his/her needs, the person has learned to utilize these behaviors to secure the necessary components from the environment to satisfy the need state. However, certain behavior included in the response may be faulty thus bringing the person into conflict with other people. Also some of the information the person has about themselves may be false (parental programming in T-A) which leads the person to view the world in a distorted manner.

It is important for the counselor to realize that these disorders do not have internal causes. Rather, the conflict is between the person's behavior and the environment at large.

With the exception of the transient situational disturbances, the personality disorders are the most frequently encountered type of behavioral disturbance encountered in the military and civilian setting.

Identifying Behaviors

Unlike neurosis where anxiety seems to be the underlying cause, personality disorders seem to be more the result of faulty learning when the individual was a child.

The following are behavioral descriptions of the various types of personality disorders. Notice that they parallel other types of disorders but personality disorders are generally less severe. This has led a number of people to speculate that personality disorders are the beginning of more severe forms of abnormal behavior, serving as the fundamental building blocks for the neurosis and psychosis.

Paranoid Personality

This person is characterized by hypersensitivity, rigidity, unwarranted suspicion, jealousy, envy, excessive self-importance (self-agrandizement) and a tendency to blame others and ascribe evil motives to them. These characteristics often interfere with the person's ability to maintain satisfactory interpersonal relations. There is no loss of reality contact. Rather, the person mistrusts the motives of others and has trouble in forming interpersonal relationships that include trust, warmth, and mutual regard. Alcohol abuse will frequently reveal a paranoid personality disorder.

Cyclothymic Personality

This person is characterized by recurring and alternating periods of depression and elation. Periods of depression may be marked by worry, pessimism, low energy, and a sense of futility. Periods of elation may be marked by ambition, warmth, enthusiasm, optimism, and high energy. These mood variations are not readily attributable to external events, although an outside event can usually be found which has had an influence on the person. This disorder should not be confused with the normal mood swings found in the vast majority of well adjusted individuals.

Schizoid Personality

This person is characterized by extreme shyness, over-sensitivity in interpersonal relationships, seclusiveness, avoidance of close or competitive relationships. Frequently, these individuals spend a good deal of time in fantasy and daydreaming in an effort to escape the uncomfortable feelings they have in ordinary social relationships. At times they react to disturbing experiences with apparent detachment. They have difficulty in committing themselves to projects or groups.

Explosive Personality

This person is characterized by gross outbursts of rage or of verbal or physical aggressiveness. These outbursts are strikingly different from the person's usual behavior, and later he/she may be repentant for the outbursts. These persons are excitable, aggressive and over-responsive to environmental pressures. It is the intensity of the outbursts and the individual's inability to control them which sets the person apart. This type of person does not show this type of behavior exclusively when drinking, but also during long periods of sobriety. Guilt and contrition usaully follow an outburst, and the person is truly perplexed by his/her behavior.

Obsessive Compulsive Personality

This person's behavioral pattern is characterized by excessive concern with conformity to laws and adherence to standards of conscience. Individuals in this group may be rigid, over-inhibited, over-conscientious, over-dutiful, and unable to relax easily. This type of personality structure is frequently found in the military setting where it is frequently seen as highly adaptive. Individuals with this personality often have difficulties in those circumstances which require adapting to nonstructured settings. Quick or sudden changes in routine often results in the individual feeling a loss of equilibrium and an inability to cope with the demands of the situation.

Hysterical Personality

These persons are characterized by excitability, emotional instability, and self-dramatization. This self-dramatization is always attention-seeking and often seductive, whether or not the person is aware of its purpose. These personality types are immature, self-centered, often vain, and usually dependent on others. In talking with these individuals, the counselor often gets the impression that they are on stage, dramatizing their plight in life for the maximum effect on the audience. They portray themselves as the "victim" while awaiting the "rescurer".

Antisocial Personality

This term describes individuals who are basically unsocialized and whose behavior pattern brings them repeatedly into conflict with society. They are incapable of significant loyalty to individuals, groups, or social values. They are grossly selfish, callous, irresponsible, impulsive, and unable to feel guilt or to learn from experience and punishment. Frustration tolerance is low and they tend to blame others for their behavior. They attempt to "con" people and are unconcerned and unfeeling about the pain they bring others. Freud explained this disorder as arising from a weak super ego (conscience) which allows the person to seek gratification of ID impulses with little or no regard for the welfare of others.

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Passive-Aggressive Personality

This person is characterized by both passivity and aggressiveness. The aggressiveness may be expressed passively, for example by pouting or sulking, procrastinating, intentional inefficiency, or stubborness. These behaviors reflect hostility which the individual feels he/she dare not express openly. Often the behavior is one expression of the patient's resentment at failing to find gratification in a relationship with an individual or with institutions.

Passive Dependent Personality

The person with this personality disorder has a high need for approval from others, and appears to be docile, helpless, and searching for support. At times their manner is one of passive acceptance along with a total lack of assertion. There is a strong sense of inferiority and a fear of being abandoned by others. These people lack coping mechanisms to function on their own, but may do well when attached to someone or something stronger than themselves. If abandoned by death or divorce of the stronger partner, they fall back to almost infantile levels of functioning.

NEUROSIS

The chief characteristic of neurosis is anxiety. Anxiety is an emotional state similar both physiologically and psychologically to fear, but the anxiety is brought about by the way the person perceives the world around him/her. The anxiety may be felt and expressed directly, or it may be controlled unconsciously by conversion, displacement and various other defense mechanisms.

Unlike the psychosis, the neurosis manifest neither extreme distortion or misinterpretation of reality, nor extreme personality disorganization. The person is aware that their mental functioning is disturbed, and as a result, this group is very prone to seek out help in coping with the patterns of anxiety. Unlike the personality disorders which arise primarily as a function of faulty learning patterns, the neurosis stem from injunctions given the person during childhood.

Identifying Behaviors

The following are behavioral descriptions of the five most common types of neurosis which you are likely to encounter.

Anxiety Neurosis

Free-floating anxiety -- person is extremely anxious about everything
Inability to concentrate
Difficulty in making decisions
Extreme sensitivity
Discouragement

Sleep disturbances
Excessive sweating
Sustained muscle tension
Somatic (body/physical) concerns

Phobic Neurosis

A phobia is a consistent fear of some object or situation that presents no real danger to the person or in which the danger is exaggerated out of proportion to its actual seriousness. The following list of the common phobias and their objects will give some hint of the variety of situations and objects around which phobias may be centered.

Acrophobia -- high places
Agoraphobia -- open places
Algophobia -- pain
Astraphobia -- storms, thunder, and lightening
Claustrophobia -- closed places
Hematophobia -- blood
Mysophobia -- contamination or germs
Monophobia -- being alone
Nyctophobia -- darkness
Ocholophobia -- crowds
Pathophobia -- disease
Phyrophobia -- fire
Syhilophobia -- syphilis
Zoophobia -- animals or some particular animal

Obsessive - Compulsive Neurosis

The primary characteristic is persistent unwanted thoughts, urges, or actions that the person cannot stop and which he/she knows are irrational. The person feels compelled to carry through with these behaviors, thus the compulsive element. Anxiety and distress are present either if the person is prevented from completing the compulsive ritual or if they are concerned about being unable to control it.

Depressive Neurosis

The most frequently seen behaviors in neurotic depression are:

Dejection
Discouragement
Sadness
High levels of anxiety and apprehensiveness
Diminished activity
Lowered self confidence
Lack of interests
Loss of initiative
Appetite loss
Sleep loss (dawn awakening)

Hypochondrical Neurosis

The behavioral picture in the hypochondrical neurosis is composed of:

Multiplicity of complaints about physical illness
Morbid preoccupation with digestive and excretory functions
Indiscriminate use of a wide range of medications
Excessive reading of medically oriented books and journals

PSYCHOPHYSIOLOGIC DISORDERS

According to the DSM-II, this group of disorders is characterized by physical symptoms that are caused by emotional factors and involve a single organ-system, (stomach, heart, etc.). Changes in the organ involved are those that normally accompany certain emotional states, but in these disorders the changes are more intense and sustained. The individual may not be consciously aware of his/her emotions and the impact that they are having on his/her body.

Unlike the hypochondrical neurosis, these disorders produce a real physical illness in the person with the emotions being the cause. These disorders should be diagnosed and treated only by competent medical personnel. The following are a list of the more common types of psychophysiological disorders.

Skin disorder -- skin rashes, etc.
Musculoskeletal disorder -- backache, tension headaches, etc.
Respiratory disorder -- bronchial asthma, hyperventilation, etc.
Cardiovascular disorder -- hypertension, tachycardia, etc.
Gastrointestinal disorder -- peptic ulcer, chronic gastritis, etc.

PSYCHOSIS

According to the DSM-II, "Patients are described as psychotic when their mental functioning is sufficiently impaired to interfere grossly with their capacity to meet the ordinary demands of life. The impairment may result from a serious distortion in their capacity to maintain contact with reality. Hallucinations and delusions, for example, may distort their perceptions. Alterations of mood may be so profound that the patient's capacity to respond appropriately is grossly impaired. deficits in perception, language and memory may be so severe that patient's capacity for mental grasp of his situation is effectively lost."

In the following section we will discuss the functional psychosis, those which seem to arise from psychological rather than organic causes. The major symptoms seen in the psychotic patient are: Disorientation, delusions, hallucinations, emotional disturbances, disturbances of verbal communication, and disturbances of non-verbal communication.

- Disorientation -- the person who is disoriented does not know who he is, where he/she is, or what time of the day, week, month, or year it is.

- Delusions -- the person who is suffering from delusions holds beliefs which are contrary to reality even in the face of clear evidence to the contrary. The most typically cited is the belief that one is Christ.

- Hallucinations -- are the perception of objects and events without external stimulus. Hallucinations are usually classified in terms of the senses that are involved. While visual (seeing) and auditory (hearing) hallucinations are the most common in psychotic persons, sometimes hallucinations involving taste, smell, touch, and body sensations are reported by the patient.

- *Emotional disturbances -- Some emotional disturbances are extremely impulsive, others seem to have a complete lack of emotional responsiveness, and others manifest responses which are totally inappropriate to the situation.

- Disturbances of verbal communication -- some of the most striking symptoms of psychosis are seen in the language of the person. At times the verbal communication resembles a "word salad" with words being strung together without any apparent rhyme or reason. Often the person will invent new words, neologisms, which have meaning only to him/her.

- Disturbances of nonverbal communication -- often the person will sit silently for hours, or engage in strange posturing and gestures which are understood only by the person displaying the behavior.

The Schizophrenic Reactions

The schizophrenic reactions are the most common of all the psychosis, constituting approximately 74%. Emotionally these persons are apathetic or indifferent, or they overreact to stimuli. Their thinking is likely to be bizarre and often regressive. Delusions and hallucinations of all types are common. Speech may show distinctive changes in the form of rambling, or there may be gross changes such as neologisms, echolalia (repeating verbatium what others say), or incoherence. An example of the unlogical thinking process of the schizophrenic is illustrated by the person who thought that he was Switzerland. Following the rules of normal logic it seems incredible that a human being could entertain such a thought. However, the patient's thinking followed the line of "Switzerland loves freedom, I love freedom. Therefore, I am Switzerland." Some of the schizophrenic reactions are: simple, hebephrenic, paranoid, and catatonic.

- Simple -- characterized by a slow and gradual reduction of external attachments and interests (withdrawal) and by indifference leading to impoverishment of interpersonal relations, mental deterioration, and a lower level of functioning. The simple schizophrenic gives the impression of being dull mentally. They frequently drift into a life of vagrancy, delinquency, and a dull shiftless lifestyle.

- Hebephrenic -- characterized by disorganized thinking, shallow and inappropriate emotions, (unpredictable giggling, silly and regressive behavior and mannerisms) and frequent physical complaints. Delusions and hallucinations, if present, are brief and not well organized. These patients show a rapid detoriation of thinking ability and the fragmentation of their thinking and emotional life is marked.

- Paranoid -- this type of schizophrenia is characterized by the presence of persecutory or grandiose delusions, often associated with hallucinations. It is one of the most commonly seen forms of mental illness. Excessive religiosity is sometimes seen. The person's attitude is frequently hostile and aggressive, and the behavior tends to be consistent with the delusions, i.e., if the person believes that he/she is Christ, he/she will act the part out. In general the disorder is not as extreme as the hebephrenic and catatonic types, perhaps because the person uses the mechanism of projection, which ascribes to others characteristics they cannot accept in themselves.

- Catatonic -- the most common symptom is a generalized inhibition of physical movement, although in some cases there is excessive movement, grimacing, overtalkativeness, and unpredictable emotional outbursts. The most classic catatonic symptoms are related to the stupor, and include a combination of silence, rigidity, and the peculiar quality of waxy flexibility of the body. The arm or leg of the patient can be placed in any position, and the limb remains in that position, sometimes for minutes or even hours. The person may sit or stand in one position, refusing to talk to anyone and seeming not to pay attention to anything that is said. Sometimes there is a rigidity of the muscles. Occasionally there may be strange gesturing, posturizing, stereotyped movements.

There are a number of other types of psychosis, such as manic-depressive, paranoid states, and psychotic depression. However, the conditions are relatively rare and the interested student is referred to any good, current textbook of abnormal psychology for complete descriptions of these disorders. The probability of encountering an individual in your job with one of these latter types of disturbance is remote. However, should this occur you will be able to recognize them from the behavioral descriptions given under the opening of this section.

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ORGANIC BRAIN SYNDROMES (OBS)

The DSM-II defines a number of psychiatric conditions relating to alcoholism under the heading of "Psychosis associated with organic brain syndromes." These, and other OBS conditions involve destruction of brain tissue due to a number of factors, i.e., age, poisons, and diseases. Since they have special applicability to the drug and alcohol counselor, these alcohol related conditions will be discussed below.

Alcoholic Psychosis

Delirium Tremens. This is a variety of acute (sudden and reversible) brain syndrome characterized by delirium, coarse tremors, (uncontrolled shaking of limbs), and frightening visual hallucinations usually becoming more intense in the dark. The condition develops after prolonged periods of heavy drinking, and is likely to appear in patients who have a history of years of alcoholism and who are suddenly withdrawn from alcohol. The first signs of the onset include a lack of appetite, increasing restlessness, irritability, and fitful sleep with disturbing dreams. These symptoms are accompanied by mounting fear and apprehension. In the excited phase of delirium tremens, the psychological symptoms include confusion and clouded consciousness. Disorientation for time and place is common, although the person will remember who they are. The hallucinations are visual and tactile, with the patient seeing his/her room alive with vermin, insects, and rodents.

Even with proper medical attention and in a hospital environment, the alcoholic may die from delirium tremens. Some may be so frightened by their hallucinations that they attempt suicide. The delirium typically lasts from three to six days and is generally followed by a deep sleep. When the person awakes, they have few symptoms, but may be badly scared and not resume drinking for a period of weeks. However, without therapy, the alcoholic most often will resume drinking again.

Korsakov's Psychosis. This syndrome, first described in 1887 by Sergei Korsakoff, is characterized by disorientation, memory impairment, and faulty memory. The syndrome, while associated with alcoholism, is a vitamin deficiency secondary to alcoholism and is found in other conditions as well. It is frequently detected in alcoholics when what appeared to be an attack of delirium tremens fails to clear. Instead of recovering within a few days, the person remains confused and disoriented. The alcoholic fails to recognize friends or relatives, and a serious memory loss is apparent. Superficial conversation with the alcoholic may reveal a reasonably clear consciousness. It is only when the patient is carefully questioned that the true extent of the impairment is recognized. As long as the individual limits their conversation to the immediate surroundings and circumstances, they appear to function in a normal manner. But as soon as recall is necessary, the patient resorts to filling-in gaps in his memory with what appears to be erroneous info. The prognosis for Korsakoff's syndrome is poor, since the removal of the toxic condition ordinarily does not bring about complete recovery.

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Alcohol Paranoid State

This is a paranoid state that develops in chronic alcoholics, generally male, and is characterized by excessive jealousy and delusions of infidelity by the spouse. Patients may react quite violently towards others, and many police blotter incidents are involved with this type of individual. The alcoholic may well be aware of social distancing on the part of his/her spouse, due in large measure to his/her drinking behavior. The alcoholic uses the mechanism of projection, placing the blame and responsibility on the spouse rather than admit to their drinking problem.

ASSUMPTION THAT LABELS ARE COMPLETE ENTITIES

One of the problems with using labels is that labels are often taken to be complete entities, even when the label is not intended to be an entity or whole complete thing. Labels are not people; labels referring to people are complete in themselves. Labels are used to describe classifications of behavior. A person is much more than a type of behavior. For example, "obsessive compulsive" is not a disease that a person catches; rather, it is a description of a behavior pattern that the person may show at certain times and under certain conditions. This behavioral description may be more accurate for one person than another person. If you assume that everyone who is classified "obsessive compulsive" is just alike, you may be in for a big surprise, because most people who tend to be "obsessive compulsive" are not exactly alike; in fact they may be quite different in some aspects of their behavior. The danger in using labels as complete entities is in the assumption. The assumption that because a person has some of the characteristics of a label, that person has all the characteristics of the label. If you assume that all alcoholics are just like the one alcoholic you know, you could make a lot of mistakes about alcoholics. Alcoholics can be very different. Alcoholics are more than the label, they are individual people who have some kind of a problem with drinking alcohol.

LABELS ARE IMPRECISE

Labels do not give a complete picture of behavior. They create a distortion in communication, and they can create distance between clients and counselors. Their importance lies in the fact that they show adjustment reactions to life. Psychiatric labels are often taken to describe people, when all they begin to do adequately is describe behaviors. Labels often do not describe behavior very well either. For example, many people in mental hospital beds are labeled as "undifferentiated schizophrenic." But when we look at this diagnosis closely, we may find that most people with this classification are from the lower socio-economic classes. The question arises, "Is the label correct, or is the label a function of the diagnoser and his/her social class?"

LABELS ARE DIFFICULT TO CHANGE

"Once a criminal, always a criminal" is an old cliche that is appropriate for labels. Labels make reintegration back into a society very difficult, if not impossible. It is as if people who are given a psychiatric label have a blot or mark placed on their foreheads for life. The label is not only visible to others, but more harmfully, stays in the mind of the person for the remainder of his/her life. Unfortunately, there is no legal process (such as a name change) for having the psychiatric labels removed. Once a person is categorized, observers tend to look for the behavior which the label describes. Looking for the behavior leads to seeing the behavior more frequently when it occurs, and even seeing the behavior when it is not present. It then becomes difficult for the labeled person to prove he/she is other than what the label indicates. Do you know what discrimination is? People with labels do because they have been treated differently because of their label. They have been stereotyped and it is very difficult to change their label.

PEOPLE REACT TO THE LABEL RATHER THAN THE PERSON

People often react to the label rather than the individual. Labels tend to encourage depersonalization of clients. For example, have you ever heard someone say, "How many alkies do you have?" or "How many druggies?" In the forword of the *Diagnostic and Statistical Manual of Mental Disorders*, information is given concerning labels and their selection of terms to classify mental illness. Their intent was to choose terms which they thought would facilitate maximum communication within the medical and social professions, and reduce confusion and ambiguity. The committee stated, however, that rationalists may be prone to believe the old saying that, "A rose by any other name would smell as sweet," but psychiatrists and psychologists know that irrational factors belie its validity, and that labels, by themselves, condition our perceptions of reality.

DIFINITION OF PATHOLOGY

Webster's Dictionary defines pathology as, "The study of the essential nature of diseases and especially the structural and functional changes produced by the diseases." In this sense, pathology is related to mental disease.

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MAJOR SYMPTOMS OF PATHOLOGY

Insomnia

Inability to sleep and/or early morning awakenings usually are related to some worry or anxiety. If consistent, or if it interferes with normal life functioning, this may be a symptom of mental illness. A person suffering from insomnia should be referred to the mental health clinic for evalution. In your referral consult, ensure you indicate the circumstances surrounding the insomnia. Be sure to include the fact that the person has been a drug or alcohol abuser if that is the case. The physician may prescribe drugs to assist sleeping, and it is helpful for the doctor to be aware of a history of drug or alcohol abuse.

Weight Loss

Unexplained weight loss may be a symptom of physical illness as well as psychological problems. If the weight loss is unexplained and extreme, and particularly if food does not taste good to the person and he/she is not hungry, the client should be referred for an evaluation.

Oversleep

If the client complains of oversleep (12 or more hours a day) chances are that some physical or psychological problem is present. It is best to get the mental health and/or physician to check this problem out.

Physical Deterioration

If your client shows a marked physical deterioration of physical appearance and cleanliness you may ask the client the meaning of the change in appearance. If the answer is unsatisfactory, or if there is a marked physical (body) deterioration, it is best to refer the client for an examination.

Hyperactivity

Hyperactivity such as compulsive pacing, fidgeting, shaking, inability to relax or sit still may be an indication of being "high" on amphetamines, withdrawing from sedative hypnotics or alcohol, or a symptom of great anxiety. If a person is very hyperactive you should refer the person for an evaluation. A urinalysis could verify the abuse of a drug. Diagnosis of withdrawal could save the person's life. And anxiety-related hyperactivity could indicate severe psychological problems. Other causes of hyperactivity could be present, and so you want to have the medics check this symptom out.

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Inappropriate Affect

If your client often shows inappropriate affect (the wrong emotion for what he/she is saying or experiencing), chances are that something serious is wrong. If the person is laughing when he/she should be crying in extreme ways, you best refer the client for a psychiatric evaluation. Be sure to include the situations in which the inappropriate affect occurred in your consult.

Blunted Affect

Blunted affect means having no emotions, especially when emotions should be expressed. A constant dead-pan face when it would be appropriate to show emotions may be an indicator that these persons are keeping themselves from feeling emotions because the emotions are too painful. If the affect is severely blunted, it is best to refer your client for an evaluation.

Hallucinations

When your clients see things or hear voices that are not there, they are likely to be experiencing an hallucination. The hallucination may be the result of taking a drug or withdrawal from a drug. Or an hallucination may be the result of psychological problems. It is best to escort or consult a medic when a person is currently having hallucinations. If the person has experienced hallucinations, have the person evaluated by mental health.

Suicide

Thoughts of suicide, suicide-like statements, and suicide attempts should be referred to the mental health clinic. Suicide statements include plans for committing suicide, and statements like, "I gave her my car because I won't be needing it any more."

Uncontrollable Weeping or Rage

If your client is unable to control his/her emotional expression after a reasonable time, chances are that you should refer the client to mental health for an evaluation. Uncontrolled weeping or rage is often a symptom of mental illness.

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EXERCISES

1. Explain the criteria of statistical standards to define mental illness.

2. What is an example of using societal standards to define mental illness?

3. If large numbers of persons seek treatment for a condition, is the condition classified as mental illness? Which principle of defining mental illness does this illustrate?

4. If a person is unable to function normally as a parent, a spouse, a worker, and a member of the community, and this person is said to be mentally ill, which criteria for defining mental illness is being applied?

5. What is the difference between the statistical occurrence approach and the number seeking or referred to treatment method of defining mental illness?

6. Do psychiatric labels describe people well? Why?

7. How can a label shape your perception of a labeled person?

8. What is meant by the statement, "Labels are often taken as entities."

9. How are labels imprecise?

10. What should you do if you notice one or more of the symptoms of pathology?

11. Do any of the symptoms by themselves indicate mental illness for sure?

12. What is blunted affect?

13. What may extreme hyperactivity be a sign of?

SUMMARY

The areas covered in the study guide and workbook will enable you to understand the criteria for defining mental illness, the problems with labeling, the major categories of mental illness, and symptoms of pathology. You need to remember these concepts to understand pharmacology, crisis intervention techniques, and understand when to refer clients to the mental health clinic for evaluation.

EGO DEFENSE MECHANISMS

You will better understand client behavior if you can identify ego defense mechanisms. This study guide will provide information about nine defense mechanisms that people use. When you complete this study guide, you will know that everyone uses ego defense mechanisms to some degree. Some people use ego defense mechanisms continually in an exaggerated and rigid manner. This exaggerated and rigid style makes it harder for these people to satisfy their needs and keeps them from being happy.

You'll be given data in a series of rectangular boxes that are divided into two sections. We will refer to the whole rectangular box as a frame.

FRAME	

You will respond to the data in the left side of the frame by writing your answer in the blanks in the statement. A word is needed in each blank (____) to complete the statement.

A. Ego defense mechanisms are mental devices used unconsciously by all of us when our self image is threatened by our own feelings. An unconscious mental device used to protect our self image is known as an ___ _____ _____.	
B. (data related to the frame above will be printed here.) EXAMPLE	ego defense mechanism

2. Normal individuals use ego defense mechanisms to screen out minor unpleasantness without distorting reality. In such a case, the cost of maintaining one's self-esteem is not great. One way to determine the cost of the ego defense mechanisms is to consider how much _____ is distorted.	ego defense mechanisms
3. Ego defense mechanisms help us control those feelings and thoughts that get in the way of our getting along well with our friends and loved ones. This is a healthy and adaptive use of defense mechanisms. If the defenses are used so excessively they make us rigid and unnatural with our friends, and keep us from developing satisfying relationships. In such a case, our self-esteem might be maintained at the price of _____ _____.	reality
4. Thus, _____ _____ _____ can be a help or a hinderance in forming satisfying relationships, depending on how we use them.	satisfying relationships
5. Remember that ego defense mechanisms are unconscious in nature. That means that they are used without the user's awareness unless someone makes the user aware of what he/she is doing. Until someone tells him/her, the person using an ego defense mechanism is unaware that he/she is using it. TRUE _____ FALSE _____	ego defense mechanisms
6. Most people use ego defense mechanisms to screen out unpleasant thoughts and to maintain self-esteem as it is. In fact, ego defense mechanisms are used by _____.	TRUE

7. Some people can keep self-esteem together only by relying excessively on ego defense mechanisms. In such cases, the ego defense mechanisms may save the individual from actual psychosis, or may serve to keep the psychosis from being worse than it already is. Ego defense mechanisms are thus used by healthy and by mentally ill individuals. They always provide some service to the individual, but it may be at great cost. The mental devices used by normals to maintain their contentment and self-esteem are the same ones used by the mentally ill to keep themselves from getting even sicker. They are called ___ _____ _____.	everyone (normals)
8. To summarize: Ego defense mechanisms are mental devices used unconsciously by all of us when our self-concept or self-esteem is threatened by our own emotions or by our interactions with others.	ego defense mechanisms
9. The first ego defense mechanism that we shall study is called identification. Identification is the unconscious defense mechanism by which a person patterns himself after someone else. When an individual patterns himself unconsciously after someone else, he is using the ego defense mechanism of _____.	no response necessary
10. Hopefully, a child identifies with healthy, loving parents. In some cases, however, children identify with maladjusted parents, or even with people that they are afraid of. In either case, identification is a primitive method of relating and of avoiding loneliness. For better or for worse, the process of patterning oneself after another is called _____.	identification

11. A healthy child with good, loving parents can identify with his/her parents and thus "keep his/her parents with him/her" when he/she is away at school by the simple process of being them. A child who identifies with parents and acts like them even when he/she is away from his/her parents is also avoiding _____.	identification
12. Patterning oneself after another is a part of forming one's identity. In the process of solidifying a stable personality, we all identify with bits and pieces of many people. There are some people, however, who identify to such a degree that they cannot distinguish between themselves and the other person. In these cases, it seems that avoiding loneliness is more important than forming an identity. _____ is an ego defense mechanism used by the healthy as well as by the mentally ill.	loneliness
13. Consider this example: A young girl patterns herself after her mother, who is a good wife and a loving parent. This girl will probably grow up with a healthy self-image of herself as a well adjusted woman. She is using the ego defense mechanism of _____.	identification
14. Consider another example: A young girl who is terribly afraid of being rejected identifies with her mother so closely that she feels that she actually is her mother. This identification is at great cost to the girl because it distorts _____.	identification
15. Remember, identification, like all of the other defense mechanisms, is an unconscious process. Thus, it differs from ordinary imitation which is done voluntarily and consciously. Identification is an _____ process.	reality

16. Regression is another frequently used ego defense mechanism. Regression is the ego defense mechanism by which a person returns to patterns of thinking and behaving that he/she used in childhood. Regression is used at times to increase the fun and enjoyment of our lives. It plays a large part in recreation and jokes. It is also used to solve present day adult problems by means that were more appropriate for a child. The process of returning to less mature levels of development is called _____.	unconscious
17. Regression is used to cope with current problems by means of thinking and behaving that were used at a time when life was more comforting and less threatening. It is an attempt to use tried and true ways of behaving and thinking that once worked. An adult that attempts to cope with current stresses by whining and stamping his/her feet is using _____.	regression
18. All of us may have a "temper tantrum" at some point or another. This use of "childish behavior" is called regression. When the mechanism of regression is used occasionally at a time of particular stress to relieve tension, we need not concern ourselves too much. TRUE _____ FALSE _____	regression
19. When a grown man or woman constantly indulges in childish, inappropriate behavior, the mechanism of regression is being utilized in an abnormal way. The ultimate form of regression is exemplified in the very mentally ill patient who curls up in the fetal position. The attempt to solve one's problems by returning to a less mature level of development is known as _____.	TRUE

20. Adults are aware of how reality can sometimes prevent us from getting what we very much desire, whereas, children cannot see why they cannot have what they want. Sometimes adults return to the kind of unrealistic thinking typical of childhood and feel that their fantasies are reality. This use of patterns of thinking typical of an earlier period is also an example of regression. Using patterns of thinking or behaving typical of earlier periods of life is called _____.	regression
21. The two ego defense mechanisms that we have considered up to this point are called _____ and _____.	regression
22. Identification is the process of patterning yourself after another, and regression is the return to earlier patterns of thinking or behaving. Both are examples of _____ _____ _____.	identification regression
23. A way of saying that ego defense mechanisms operate without our awareness is to say that they are _____.	ego defense mechanisms
24. Ego defense mechanisms are used by normal people and by the mentally ill to avoid thinking of painful things. If they are not used at the expense of giving up reality or of giving up satisfying relationships, they are very helpful to us. Another ego defense mechanism that we will consider is called repression. By means of the ego defense mechanism of repression, we are able to banish unacceptable ideas, thoughts, or impulses from consciousness. The defense mechanism by which an individual excludes painful thoughts or desires from his consciousness <u>without being aware of doing so</u> is called _____.	unconscious

25. Repression is the keystone of all the ego defense mechanisms, and is frequently used by all normal people. Difficulties begin when repression fails and is no longer able to keep unwanted thoughts out of our awareness. At such a time, other defenses are called in to bolster the failing defense mechanism of repression. At this point, symptoms of mental illness may well begin, as other defense mechanisms are used at greater cost to the individual. The ego defense mechanism that makes up the first line of defense is called _____.	repression
26. When repression fails to exclude painful thoughts from our awareness, we begin using more defense mechanisms. Often this causes difficulty because other defense mechanisms are used at a _____ _____ to the individual.	repression
27. Normal people use repression so they will not think about disturbing facts of life. As long as it is not used too often, it makes our life smoother and less stressful. In neurotics and psychotics, repression is not enough to keep the unwanted thoughts out of awareness. In an attempt to bolster repression, an individual may give up the ability to determine what is real, or may give up satisfying relationships. Both normal people and people with mental illness use repression, but for people with mental illness it is not enough to do the trick, and other defenses are called in. TRUE _____ FALSE _____	greater cost
28. Here is an example of the normal use of repression. A young man's father dies and all the young man can think of are the good times he and his father had together. He simply does not think of all the fights that he and his father had. In his attempt to become unaware of the painful memories of fighting with his departed father, the young man in this example is using the ego defense mechanism of _____.	TRUE

29. Here is another example of repression. A soldier sees his best buddy killed in combat, and he develops an amnesia for the entire incident. In his attempt to keep out of his awareness the painful memory, he uses the defense mechanism of _____.	repression
30. Repression, you will recall, is not something that goes on voluntarily. As a matter of fact, it goes on entirely without the awareness of the individual, and is therefore _____.	repression
31. A memory that has been erased from the conscious mind by means of repression is not entirely unavailable. Sometimes, the individual can "dredge up" the experience with the help of psychotherapy or hypnosis. Nevertheless, without some drastic change in the situation, a memory that has been repressed is out of a person's _____.	unconscious
32. The basic ego defense mechanism upon which we generally rely is called _____.	awareness or conscious mind
33. Another defense mechanism is called denial. Denial is a more primitive ego defense mechanism than repression. By repression, an individual simply forgets some painful memory. Through the use of denial, he/she flatly denies that some clear part of the real world exists! For example, a young woman has difficulty accepting the fact that her baby boy has just died of pneumonia. Instead of mourning, she refuses to admit that he is dead. In fact, she continues to buy baby food and little clothing, and pretends the baby is asleep in the other room. In her attempt to deny the painful reality of her son's death, she uses the ego defense mechanism of denial. This kind of denial often occurs to some degree at times of loss. The ego defense mechanisms by which a person refuses to acknowledge a painful reality is called _____.	repression

34. Here is another example. An old man claims that he is still able to do everything that he could do when he was much younger. By refusing to acknowledge the loss of some of his abilities, he is using _____.	denial
35. Whenever denial is used, the real world is dostorted to some degree. Normal people use denial from time to time, but do not markedly distort reality. People with mental illness use denial more extensively, and distort reality to a considerable extent. Example: A young man is considerably shaken by the death of his young wife. For days, he keeps muttering "it can't be, she isn't dead, I know she isn't dead." However, at the funeral he breaks down and cries at her loss. He is a normal person using the defense mechanism of _____.	denial
36. Here is another example: A mother is unable to accept the fact that her son is mentally deficient. Despite evidence from her doctors and from numerous teachers and principals, she continues to enroll the child in school after school. Here we can see that in her use of the defense mechanism of denial, she has distorted _____.	denial
37. Another ego defense mechanism is called projection. By projection, we blame someone else for our own thoughts, feelings, or deficiencies. "Pot calling the kettle black" is a good way to describe the ego defense mechanism of _____.	reality
38. Here is an example of projection: A married man has been having intense urges to have an affair with another woman, but he feels that even such an idea is sinful. Nevertheless, he continues to have such thoughts until the time that he suddenly begins to suspect that his wife is unfaithful. By attributing his own feelings to his wife, he escapes the feeling of guilt. In his attempt to attribute his own feelings to his wife, he uses the defense mechanism of _____.	projection

39. In the example above, the man was unable to keep his "sinful thoughts" out of his mind. Another way to say this is to say that there was a failure of the defense mechanism of _____.	projection
40. Here is another example: A young man is furiously angry with his own father and wants very badly to kill him. This thought troubles him, but he cannot banish it from his mind. Then one day, he suddenly begins to fear that his father wants to kill <u>him</u>! In this example, the young man attributed his own unacceptable feelings to someone else, namely his father. By doing so he used the mechanism of _____.	repression
41. In the above example we again see that projection occurs when repression fails. If the young man had been able to simply forget about his anger toward his father he would have been much better off. Instead, repression was not enough and he had to call in projection, a more primitive defense. The trouble with this is that he now runs around in fear of his own life. He has kept the painful thought of his anger toward his father out of his mind at great cost.	projection
42. Projection is also used by normal people. All of us have had the experience of covering some mistake we have made by saying "Its not my fault, its your fault" to our partner. For example, in a softball game, the first baseman may claim that he missed a perfectly good play because the ball was thrown too wide. If this does not occur too often, it is a _____ example of projection.	no response required
43. Projection is of particular importance to those who work with the mentally ill because it is the <u>basic mechanism used by those patients who feel they are being persecuted by others.</u> In the example above, the young man was feeling persecuted by his father, but in fact, it was the young man who was the angry one. The defense mechanisms by which a person blames someone else for his/her own thoughts or feelings is called _____.	normal

44. Now let us turn to another ego defense mechanism used by normals and by neurotics. It is called <u>reaction formation</u>. This ego defense mechanism is used when repression is failing. When repression is unable to keep some painful thought or feeling from consciousness, a person may develop a strong conviction <u>opposite</u> to his/her original unacceptable attitude. This is called <u>reaction formation</u>.	<u>projection</u>
45. Thus, a man may be very troubled by his intense interest in pornography. Repression alone is not sufficient to keep these thoughts out of his mind. Therefore, he reinforces his repression by becoming an ultra-conservative who crusades <u>against</u> pornography. In this example, a man developed an attitude <u>opposite</u> to his unwanted impulses in an attempt to keep them in check. He used the ego defense mechanisms of _____ _____.	<u>reaction formation</u>
46. <u>Reaction formation</u> is typically used when the individual is unable to keep out of his/her awareness some desire that society would find unacceptable. Repression is not sufficient to keep the desire unconscious. In effect, the person using <u>reaction formation</u> says "Why, I don't want to do <u>that</u>; its the last thing in my mind. As a matter of fact, I passionately believe in the exact opposite!" Example: An angry young man fears showing his angry feelings as he expects they would bring social disapproval, but he is unable to "forget" about them. Instead, he develops an attitude of being extraordinarily <u>nice</u> to everyone he sees. This is an example of _____ _____.	<u>reaction formation</u>

47. The young man in the example above is not very likely to "fool" anyone that knows him very well, as the "niceness" is likely to be stiff, constant, and very much like a "front." In addition, the young man is probably not able to relax, and attempts constantly to be "nice" as opposed to being assertive as he must be in his daily life. He is too rigid, too inflexible in his attempt to be nice, rather than always angry, as he really feels underneath. Remember, since reaction formation is an ego defense mechanism, the young man's attempt to be nice rather than angry goes on out of his awareness and is _____.	reaction formation
48. Disappointments are encountered by everyone when expectations are not realized, and people learn to keep their expectations and anticipations within reasonable limits. In extreme cases of continued stress, frustrations and disappointments, many people lose hope and withdraw. Such indi iduals protect themselves from the bitter hurt of continued frustration by withdrawing and becoming passive receivers of whatever life brings.* Long-term disappointment and frustration might cause some individuals to employ mental mechanisms to avoid continued hurt and stress. One technique that could be used to escape disappointment would be to _____.	unconscious
49. Many people lose hope when suffering from alcoholism or faced with chronic unemployment or imprisonment. People in these painful situations frequently adapt themselves to a restricted way of life and withdraw from emotional involvement with other people. Alcoholics are examples of people who frequently _____ from social contact and emotional involvement with people.	withdraw

*James C. Coleman, Abnormal Psychology and Modern Life 4th Edition, 1972, Scott, Foresman and Company

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50. Many times friends and associates of an alcoholic feel rebuffed and slighted when the alcoholic withdraws. In defense of their own hurt feelings, these friends "counter-attack", and the counterattack may be the cessation of social interaction with the alcoholic. The withdrawal and the counterattack creates a cycle that often leaves the alcoholic completely isolated from others. When alcoholics _____, friends often misunderstand and feel rebuffed and slighted.	withdraw
51. The next ego defense mechanism we will consider is that of displacement. Displacement is a very common defense mechanism by which a person discharges the pent-up emotions he/she has about one person to a different, less threatening person. The most common example is of the man who is furious at his boss, but never shows it. Instead, he comes home at night and yells at his wife. He is thus discharging his pent-up emotions to a different person, a neutral one who is less threatening. He is using the defense mechanism of _____.	withdraw
52. When a man uses displacement, he does not hide his desire, or block his impulse out of consciousness, or even modify the desire very much. He just changes its direction and lets go of his emotions at someone who he thinks is safer. Of course, this is not conscious, and goes on outside of his _____.	displacement

53. Displacement is used by people with phobias. Let us consider a man who hates and fears his father. In addition, he has some very warm feelings toward his father and does not want to lose his love. Therefore, he shifts his emotions to something less threatening, but does not change them in any other way. He becomes a man who hates and fears dogs. This helps him get along with his father. In shifting his emotions from his father to the safer alternative of dogs, he uses the defense mechanism of _____.	awareness
54. There is a special form of displacement that is very important to people who work with the mentally ill. This is a subcategory of displacement known as "turning against the self". Here, just as in the usual kind of displacement, the individual shifts his/her emotions from their original object to a safer one. However, in turning against the self, he/she shifts from the original person to himself/herself. For example: A young woman is angry at her elder brother, but is afraid of him and also does not want her brother to turn away from her. Instead of staying angry at her brother, she shifts her anger and becomes angry at herself. She becomes just as furious with herself as she had been with her brother. Turning against the self is a variety of the defense mechanism of _____.	displacement
55. The danger of "turning against the self" is a big one--the danger of suicide. Often, it appears that people who attempt suicide were originally angry at someone else, and then switched and became angry at themselves. If you try to talk such a person out of being angry with himself/herself and tell him/her that he/she is really angry at someone else, he/she will not know what you are talking about. This is because the ego defense mechanisms go on without our awareness. The switch of emotions to himself/herself goes on _____.	displacement

56. Another common defense mechnaism is that of rationalization. By rationalization an individual justifies his/her actions and gives socially acceptable reasons for it in order to perserve his/her self-esteem. Rationalization is a way of finding an acceptable and logical reason for something unacceptable that you want to do. For example: A woman buys an expensive dress, and tries to excuse this by saying that she bought it to keep up appearances and help her husband's profession. Thus, the defense mechanisms whereby one finds a logical, socially acceptable reason for doing the things one wants to do is called _____.	unconsciously
57. Clearly rationalization is rather common, and people use it all the time. The other defense mechanisms are used frequently by normal people too. The big question is always the cost that the individual pays to keep his/her self-esteem and clear his/her mind of painful thoughts. In the example above, the woman paid the cost of not knowing her true motives. This lack of self-understanding might make it difficult for her to cut down her spending, but is not all that serious. Ego defense mechanisms are used by normal people. TRUE _____ FALSE _____	rationalization
58. An interesting and effective ego defense mechanism is sublimation. When an individual uses sublimation, he/she finds a vaguely similar, but socially acceptable way of satisfying his/her desires. For example: A man with sadistic traits that he tries to control may be able to find great contentment as a butcher, or perhaps a surgeon. Finding a way of doing what you want to do by changing it just enough to satisfy society is called _____. 160	TRUE

59. Needless to say, sublimation, like all ego defense mechanisms, is carried on unconsciously. A young girl who enjoys being the center of attention may be too shy to attempt to become an actress. Instead, she may become a school teacher, and still be the center of attention. This is also an example of the _____ _____ _____ of sublimation.	sublimation
60. Ego defense mechanisms, as you will recall, are mental devices used unconsciously by all of us when our self-esteem or personality organization is threatened by our own emotions or by our interaction with others. They keep us unaware of painful reality and of unacceptable feelings and thoughts within us. They are a great help to us at times, but in some situations can operate only at great cost to the individual. When they operate at the cost of clear perception of reality or of satisfying relationships, then the individual may well be suffering from _____ _____.	ego defense mechanism
61. The ego defense mechanism that we use in order to pattern ourselves after other people is called _____.	mental illness
62. Some people react to stress by returning to earlier patterns of thinking or behavior. In doing so, they use the defense mechanism of _____.	identification
63. Ego defense mechanisms operate without our awareness and are unconscious. The basic ego defense mechanism that keeps painful or unacceptable memories, desires, or ideas from our awareness is called _____.	regression
64. A young student speaks to the Dean and is told that he has definitely flunked out of the school. Nevertheless, he returns to his room and continues to study for an exam as if he had not been dropped. He is using the defense mechanism of _____. 161	repression

65. Repression allows us to not think of painful memories, but denial causes us to distort reality and refuse to believe what is clearly true. How about this example: A young man is quite concerned because he notices that he has some homosexual impulses. Then, he develops the idea that his roommate is homosexual and is trying to seduce him. He is using the defense mechanism of _____.	denial
66. People who use denial extensively do not correctly perceive the real world around them. People who use projection excessively blame others for their own thoughts and feelings, and thus distort the real world, too. Thus, both of these ego defense mechanisms when used excessively, are used at the cost of determining _____.	projection
67. People who develop the opposite attitude to their real feelings in an attempt to hide and control their real feelings are using _____ _____.	reality
68. A young woman was terribly afraid that her boyfriend would attempt to seduce her and gradually became afraid of all men. She then developed a great fear of horses, but was no longer so concerned about men. She used the defense mechanism of _____.	reaction formation
69. An alcoholic, who avoids contact with family and friends, feels that he/she must _____. to avoid the emotional pain and bitter frustration brought on by prolonged abuse of alcohol.	displacement
70. Someone who tries to convince himself/herself by means of a logical, socially acceptable explanation, that his/her incestuous sexual desires were all aboveboard is using _____ if he/she does it unconsciously.	withdraw

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71. Ego defense mechanisms are mental devices used without our awareness by all of us in an attempt to maintain our self-esteem and decrease our anxiety when we are troubled by reality or by our own thoughts or feelings. When used excessively, they can be used at great cost to the individual, and may result in mental illness.	rationalization

If you would like more information about defense mechanisms, or if you are confused about any area covered in this study guide, contact your group facilitator. Your facilitator will arrange to have your questions answered to your satisfaction.

GLOSSARY

ACUTE. Having a sudden onset, sharp rise, and short course (disease).

AFFECT. A person's emotional feeling tone. "Affect" and "emotion" are commonly used interchangeably.

ANXIETY. Apprehension, tension, or uneasiness that stems from the anticipation of danger, the source of which is largely unknown or unrecognized.

CEREBRAL. Of or relating to the brain or intellect.

CHRONIC. Marked by long duration or frequent recurrence.

DELUSION. A false belief out of keeping with the individual's level of knowledge and cultural group. The belief results from unconscious needs and is maintained against logical argument and despite contradictory evidence.

DISORIENTATION. Loss of awareness of the position of the self in relation to space, time, or other persons confusion.

EGO. In psychoanalytic theory, one of the three major divisions in the model of psychic apparatus, the other being the id and superego. The ego represents the sum of certain mental mechanisms, such as perception and memory, and specific defense mechanisms. The ego serves to mediate between the demands of primitive instinctual drives (the id), of internalized parental and social prohibitions (the superego), and of reality. The compromises between these forces achieved by the ego tend to resolve intrapsychic conflict and serve an adaptive and executory function. Psychiatric unsafe of the term should not be confused with common usage which connotes "self-love" or "selfishness."

ENURESIS. Bed wetting.

HALLUCINATIONS. A false sensory perception in the absence of an actual external stimulus. May be induced by emotional and other factors such as drugs, alcohol, and stress. May occur in any of the senses.

HYPERACTIVITY. Excessively or pathologically active.

INTERGRATION. The useful organization and incorporation of both new and old data, experience, and emotional capacities into the personality. Also, it refers to the organization and amalgamation of functions at various levels of psychosexual development.

LIABILITY. Readily or continually undergoing chemical, physical, or biological change or breakdown.

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MALADAPTIVE. Marked by poor or inadequate adaption to the life situation.

MILIEU. Environment, setting.

NEUROSIS (PSYCHONEUROSIS). An emotional maladaption characterized chiefly by anxiety arising from some unresolved unconcious conflicts. This anxiety is either felt directly or controlled by various psychological mechanisms to produce other, subjectively distressing symptoms. The neuroses are usually considered less severe than the psychoses (although not always less disabling) because they manifest neither gross personality disorganization nor gross distortion or misinterpretation of external reality. The neuroses are classified according to the predominating symptoms.

ORGANIC. Relating to, or arising in a bodily organ affecting the structure of the organism.

PARANOID. An adjective applied to individuals who are over suspicious, some of whom may also harbor grandiose or persecutory delusions, or ideas of reference.

PATHOLOGY. The study of the essential nature of diseases and especially of the structural and functional changes produced by them.

PSYCHOTIC. Relating to or marked by psychosis.

REGRESSIVE BEHAVIOR. The partial or symbolic return to more infantile patterns of reacting. Manifested in a wide variety of circumstances such as normal sleep, severe physical illness, and in many psychiatric disorders.

REPRESSION. A defense mechanism, operating unconsciously, that banishes unacceptable ideas, affects, or impulses, from consciousness or that keeps out of consciousness what has never been conscious. Although not subject to voluntary recall, the repressed material may emerge in disguised form, sometimes used as a generic term for all defense mechanisms. Often confused with the conscious mechanism of suppression.

SENILE. Exhibiting a loss of mental faculties associated with old age.

SYMPTOMATIC. Having the characteristics of a particular disease but arising from another cause.

SYNDROME. A configuration of symptoms that occur together and that constitute a recognizable condition.

SYSTEMIC. Relating to, or common to a system.

TOXIC DELIRIA. Severe disturbances in cerebral functions resulting from toxins.

TOXINS. A poisonous substance.

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1. Alfred M. Freedman, M.D. and Harold L. Kaplan, M.D., *Comprehensive Textbook of Psychiatry*, The Williams and Wilkins Company, 1967.

2. James C. Coleman, *Abnormal Psychology and Modern Life*, Scott, Foreman, and Company, Third Edition, 1962.

PLAN OF INSTRUCTION/LESSON PLAN PART I

NAME OF INSTRUCTOR	COURSE TITLE
	Drug and Alcohol Abuse Control
BLOCK NUMBER: II	BLOCK TITLE: Basic Skills and Knowledges

1 COURSE CONTENT	2 TIME

3. National Institute of Drug Abuse

a. Using pre-recorded counseling situations as stimulus, identify listener response as either levels 1, 2, or 3 according to the Responding-to-Feeling Scale.

SUPPORT MATERIALS AND GUIDANCE

Student Instructional Material
SG B-III-1-18, Counselor Training: Short Term Client Systems

Audio-Visual Aids
Cassette tape, Counselor Training: Short Term Client Systems
Cassette tape recorder

Training Method
Demonstration Performance

Instructional Guidance
The purpose of this module is to facilitate the development of the participant's ability to respond to the speaker's feelings. Students will learn to discriminate between a response that responds to feelings and one that does not. They should be able to identify and differentiate between stated feelings and undercurrent feelings, empathic and sympathetic responses, and solution-oriented and situation-oriented responses.

SUPERVISOR APPROVAL OF LESSON PLAN (PART II)

SIGNATURE AND DATE	SIGNATURE AND DATE

PLAN OF INSTRUCTION NUMBER	DATE	PAGE NO.
L3ALR73430B/L30LR7361B/L30ZR7364B	30 May 1978	19

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STUDY GUIDE

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Technical Training

Drug and Alcohol Abuse Control

GENERAL COUNSELING TECHNIQUES

PART V

SHORT TERM CLIENT SYSTEMS

April 1977

USAF TECHNICAL TRAINING SCHOOL
Lackland Air Force Base, Texas 78236

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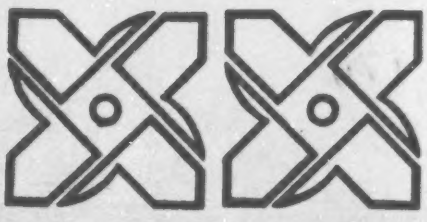
Counselor Training: Short-Term Client Systems

Training Manual for Counseling Skills



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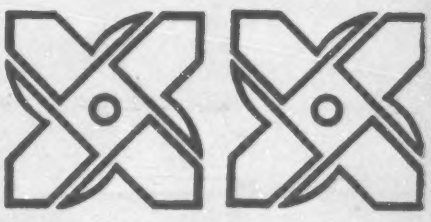

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COURSE DESCRIPTION

Purpose

To train counselors in the listening and responding skills that are basic to any helping relationship.

Goals

After completing the course, participants will be able to—

- demonstrate their listening skills by identifying to what extent client problem statements express affect;
- correctly discriminate between facilitative and non-facilitative counselor responses to a client problem statement;
- make spontaneous counselor responses that are minimally empathic, facilitative, concrete, and appropriate when presented with a client problem statement;
- identify their own feelings and attitudes that may hinder their role as a helper when confronted with client problem statements or feedback;
- utilize appropriately a twelve step problem-solving process.

Audience

All persons who are currently engaged or about to become engaged in a counseling role.

Content

The course covers three major subject areas: (1) *Empathy*, which focuses on listening and responding skills that demonstrate empathic understanding; (2) *Values and Attitudes*, which focuses on developing skills that enable the counselors to help the client explore the values and attitudes represented in his concern, and the corresponding thought processes and behavior; and (3) *Problem Solving*, which includes problem definition, exploration of alternatives, planning for change, and preparing to act on plans.

(Continued on inside back cover)

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COUNSELOR TRAINING: SHORT-TERM CLIENT SYSTEMS

Training Manual for Counseling Skills

by

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Counselor Training: Short-term Client Systems was developed by the NATIONAL DRUG ABUSE CENTER for Training and Resource Development, operated by System Development Corporation pursuant to Contract Number 271-75-4018 with the Manpower and Training Branch, Division of Resource Development, National Institute on Drug Abuse, 11400 Rockville Pike, Rockville, MD 20852. The Center includes personnel and resources from System Development Corporation; A. L. Nellum and Associates, Washington, D. C.; and, Health Control Systems, Inc., Chicago, Illinois. The opinions expressed herein are those of the authors and should not be construed as representing the opinions or policy of any agency of the United States Government.

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ACKNOWLEDGMENTS AND HISTORY

The development of this manual and the counseling skills training model it presents was begun in 1970 by Lance Harris, Ph.D., presently at American Lake Verterans Administration Hospital, Tacoma, Washington; Robert F. Dendy, Ph.D., presently at the National Drug Abuse Center; and Norman Kagan, Ph.D., Michigan State University, who also developed the Interpersonal Process Recall.

In 1972, under a grant from the Michigan Governor's Office of Drug Abuse and Alcoholism, this counseling skills training model was written in *A Survival Manual for the Drug Center Volunteer*. The authors were William Hinds, Ph.D., Mary James, Michael Gieszer, and Beth Jacobs Gillispie.

The *Survival Manual* was adopted and substantially revised by the National Drug Abuse Training Center in 1973, under its new title, *Training Manual for Counseling Skills*. For the past three years, thousands of participants and trainers from across the country have been using this manual. In an effort to be responsive to the feedback of these persons and to current developments in counseling, the *Training Manual for Counseling Skills* has been revised once again by the National Drug Abuse Center for Training and Resource Development.

For their help with this revision, we would particularly like to thank Glen Fischer and Ginny Robinson.

Beth Jacobs Gillispie
May 1977

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USING THIS MANUAL*

The *Training Manual for Counseling Skills* is organized into two major chapters and appendices. The first chapter contains an introduction to the course and describes its purpose; it presents the course goals and objectives, alternate course scheduling, and a summary evaluation report. The second chapter is the workbook that will be used during training.

The course materials are bound in a looseleaf notebook so that you can add your own notes in the appropriate sections, and keep the manual updated with any revisions issued by the National Drug Abuse Center (NDAC).

The pages in Chapter One are numbered consecutively; the pages in the workbook in Chapter Two are numbered according to their location in a particular unit and module: for example, page 3 of Module 5 in Unit II is numbered II-5-3. Pages that introduce units belong to no module and are indicated with a 0 (e.g., I-0-1 or II-0-1, etc.).

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* **PROBLEMS WITH PRONOUNS AND POLEMICS**

Throughout this manual we have had to face the problem that the content refers equally to both men and women and that we do not have a universally accepted single word in the English language to use when referring to a member of either sex. We have therefore fallen back on the universal use of male pronouns to indicate a person of either sex and hope that the readers will understand our intentions.

CHAPTER ONE

COURSE DESCRIPTION

PURPOSE

Most persons would agree that it is the counselor in the drug treatment and rehabilitation program who is the backbone of service delivery. The extent to which a counselor is effective in this role, both in the eyes of his clients and of his program, is dependent upon many factors. One major factor is the quality of the counselor's helping skills. It is toward this end that *Counselor Training: Short-term Client Systems* has been developed: to train counselors in basic listening and responding skills in the areas of empathy, values and attitudes, and problem solving.

It is not the purpose of the course to teach counseling theory. Most counselors, whether professional (degreed) or paraprofessional, can state the principles of effective helping relationships, empathy, and so on. Few can actually demonstrate effective responses that reflect these principles. Therefore, this is a "how-to-do-it" course.

Whether the training is used as a vehicle to meet the new credentialing requirements for drug abuse counselors, or as ongoing inservice work, or as an introductory or refresher course, the intent is to significantly improve the quality of drug treatment services by enabling counselors to establish and maintain more effective helping relationships with their clients.

INTENDED AUDIENCE

The course is intended for all persons who are currently engaged or are about to be engaged in counseling roles and who need to develop the skills specified in the course goals and objectives. There are no minimum skill or experience requirements.

Participants may work in programs directly related to substance abuse or in agencies whose clients have drug or drug-related problems. Examples of the types of settings from which participants have been drawn include hot lines, crisis centers, mental health centers, outreach programs, free clinics, methadone programs, therapeutic communities, inpatient and outpatient treatment systems, youth centers, runaway houses, criminal justice programs, troubled employee programs, schools, and lay counseling programs.

COURSE GOALS

The overall goal of the *CT:STCS* course is to provide participants with additional skills in the areas of empathy, values and attitudes exploration, and problem solving so that they can establish and maintain more effective helping relationships with their clients.

A second goal is to provide a learning experience for participants that increases their—

- appreciation for the responsibilities, the influence and the limitations of the counselor in the helping relationship;
- understanding of the dynamics of the helping relationship;
- appreciation of the need for self-awareness on the part of the counselor;
- understanding of the client's affective, cognitive, and behavioral processes;
- appreciation for the necessity to respond to the client as a whole person, with drug abuse or drug-related problems being symptomatic or incidental to other concerns.

MAJOR SUBJECT AREAS

Rather than approach counseling from the perspective of a single school of thought (for example, gestalt, transactional analysis, behaviorist) the course is designed with generic conceptual areas that define skills basic to any helping relationship. These are reflected in three major subject areas:

1. **Empathy.** This component provides the foundation for building trust with the client and helping the client explore the feelings (affective processes) attached to his concern. The focus is on listening and responding skills that demonstrate empathic understanding. It also includes exploration of the counselor's affective processes that may influence the helping relationship.

2. **Values and Attitudes.** This component provides the link between empathy and problem solving. The focus is on building skills that enable the counselor to help the client explore the values and attitudes represented in his concern, and the corresponding thought processes and behavior. Beyond hearing and responding to this deeper level of meaning, this component also explores the effect of the counselor's personal values and attitudes on the helping relationship.

3. **Problem Solving.** Having identified and clarified the client's feelings and values, the counselor and client can focus on rational decision making and changes in his behavior. The problem-solving component includes problem definition, exploration of alternatives, making plans for change, and preparing to act on plans for change.

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TRAINING OBJECTIVES

By the end of the counseling skills session, trainees will be able to—

- demonstrate their counseling skills by making at least 80 percent of their written response minimally empathic, facilitative and appropriate when presented with a client problem statement, as judged by objective, experienced raters;

- correctly discriminate between a Level One response and a Level Two or Three response when presented with tape recorded stimulus material four out of five times;*

- make spontaneous responses at Levels Two or Three, 80 percent of the time, as judged by a trainer, when presented with tape recorded stimulus material, and during a brief client/counselor interchange;*

- demonstrate their listening skills by correctly discriminating between a Level One, Level Two, or Level Three client statement, according to "Owning-of-Feelings Scale" (attached) when presented with tape recorded stimulus material;

- identify and correctly label their own feelings and attitudes elicited by the tape recorded stimulus material;

- formulate responses to tape recorded stimulus material and to a brief client/counselor interchange that acknowledges counselor feelings and attitudes and maintains focus on the client by appropriately using at least two of the four roadblock movers listed in the *Training Manual for Counseling Skills*;

- utilize appropriately at least 9 of the 12 problem-solving steps (outlined in the *Training Manual for Counseling Skills*) when placed in a brief client/counselor interchange. (Appropriateness of the steps chosen will be judged by the trainer, utilizing client feedback, problem content, and the problem-solving checklist.)

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*For each of the scales provided on the following pages "Responding to Feelings;" "Specific Labeling of Feelings and Sources,;" "Responding to Feelings in Conflict;" "Responding to Values."

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OWNING-OF-FEELINGS SCALE

LEVEL ONE: The speaker does not own his own feelings by—

- ***denying*** **his feelings or** ***avoiding*** **discussion of them;**
- ***detaching*** **himself from his feelings, and describing them as though they are not part of himself but come from outside himself, or are forced on him by other people or situations;**
- ***minimizing*** **feelings or talking about them in an abstract or superficial manner.**

LEVEL TWO: The speaker attempts to own his feelings by—

- **describing his feelings in a** ***vague*** **manner, or** ***distancing*** **them by using past or future terms;**
- **acknowledging his feelings but discussing them in an** ***intellectual*** **or** ***philosophical*** **manner;**
- **stating his feelings** ***without*** **clearly linking them to a** ***source.***

LEVEL THREE: The speaker owns and takes responsibility for his own feelings by—

- **identifying his immediate (here and now) feelings** ***clearly*** **and** ***genuinely;***
- **expressing the** ***intensity*** **of his feelings;**
- **specifying the** ***source*** **of his feelings.**

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RESPONDING-TO-FEELINGS SCALE

LEVEL ONE: The listener does not facilitate the speaker by—

- *denying* speaker's feelings, putting them down, ridiculing, *judging*, or offering quick *solutions*;
- responding only to the *facts*, the situation, or the storyline;
- *ignoring* the speaker's *feelings*.

LEVEL TWO: The listener facilitates the speaker by—

- *reflecting* the stated feelings of the speaker, using the same or similar words;
- maintaining nonverbal behavior that is *attentive* to the speaker;
- *accepting* the speaker's feelings by being nonjudgmental.

LEVEL THREE: The listener facilitates the speaker by—

- responding to stated feelings and to *undercurrent* feelings that the speaker has implied but has not clearly stated;
- acknowledging the *intensity* of the speaker's feelings with appropriate nonverbal behavior;
- responding to *nonverbal* cues from the speaker.

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SPECIFIC-LABELING-OF-FEELINGS-AND-SOURCES SCALE

LEVEL ONE: The listener does not facilitate the speaker by—

- responding to the speaker's stated feelings but *ignoring* the *sources* of those feelings;
- *moving* the speaker away from his immediate concerns to *irrelevant*, *impersonal*, or *abstract* issues;
- responding to speaker's stated feelings and sources in language that is *less specific* than the language that the speaker used.

LEVEL TWO: The listener facilitates the speaker by—

- responding to the speaker's stated feelings but matching it to an incorrect or *inappropriate source*;
- *reflecting* the stated feelings and sources of the speaker using the same or similar words;
- *centering* on the speaker's immediate concern.

LEVEL THREE: The listener facilitates the speaker by—

- responding to the speaker's feelings and sources in language that is *more specific* than the language that the speaker used;
- *focusing* on those feelings and sources that are most important to the speaker's immediate concerns;
- responding to *stated* feelings, to *undercurrent* feelings, and to the sources of those feelings.

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RESPONDING-TO-FEELINGS-IN-CONFLICT SCALE

LEVEL ONE: The listener does not facilitate the speaker by—

- acknowledging the speaker's feelings in conflict but *judging* one feeling to be more right or wrong than the other, taking sides, or giving advice;
- responding to *only one* of the speaker's feelings in conflict;
- recognizing the speaker's conflict but responding only to his *situational* conflict or generalizing to examples outside the speaker's personal world.

LEVEL TWO: The listener facilitates the speaker by—

- responding to the speaker's *feelings* in conflict but not to the source(s) of those feelings;
- *reflecting* the speaker's feelings and source(s) in conflict, using the same or similar words;
- *responding* to the speaker's feelings in conflict and their source(s) by using examples the speaker has described.

LEVEL THREE: The listener facilitates the speaker by—

- responding to the speaker's stated feelings in conflict and to the source(s) of those feelings using language that is *more specific* than the language used by the speaker;
- responding to the *impact* of the speaker's conflict;
- responding to *undercurrent feelings* and *source(s)* that the speaker implies but does not clearly state.

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RESPONDING-TO-VALUES SCALE

LEVEL ONE: The listener does not facilitate the speaker by—

- *judging*, agreeing with, disagreeing with, or moralizing about the speaker's values;
- *ignoring* the speaker's values;
- responding to the speaker's values using *less specific* terms than the speaker uses or generalizing to examples outside of the speaker's world.

LEVEL TWO: The listener facilitates the speaker by—

- reflecting the *stated* values of the speaker by using the same or similar words;
- responding to the speaker's values but *not* to the *feelings* associated with them;
- using examples that are *meaningful* to the speaker.

LEVEL THREE: The listener facilitates the speaker by—

- responding *more specifically* to the speaker's values;
- responding to the speaker's stated values and checking out other *undercurrent* values that may be present but not clearly stated;
- responding to the *feelings* associated with the speaker's values.

TRAINER QUALIFICATIONS

It is assumed that trainers in this counselor training program are committed to safeguarding and perpetuating training that contributes to the strengthening of high quality care delivery systems.

The small-group work must be conducted by a trainer or training team with a trainer-trainee ratio of one to six. The total training group size may range from six to thirty, with eighteen or twenty-four as the optimal large-group size. Every member of the training team should have—

- successfully completed the *Counselor Training: Short-term Client Systems Course;*
- received training for trainers specific to this counseling skills training model;
- previous successful experiences in counseling situations similar to those that will be faced by the trainee population (optimally, in similar work settings);
- strong small-group process and training skills;
- the necessary resources for back-up supervision, or access to third party resources for supervision and/or referral when needed.

Being thus qualified, the trainer will have firsthand knowledge of the training goals, structure, and developmental learning stages of the course, and will also be able to anticipate and deal with the impact of the training experience on the trainee.

The trainer is expected to have mastery of the content, concepts, and implementation of the skills presented in this manual. The successful trainer (as well as counselor) functions within a conceptual framework—one which accounts for developmental learning as well as intra- and interpersonal dynamics. It is assumed, therefore, that the trainer's conceptual framework is in harmony with the theory and objectives underlying this training model.

Having had some successful experiences in helping relationships similar to those in which the trainees are involved in their work settings, the trainer will have personalized knowledge that he may share with his trainees at appropriate times. It will also enable him to relate more effectively to the problems and successes in helping relationships that the trainees present.

Having a strong grasp of small-group process, theory and skills will enable the trainer to create an environment that facilitates learning; manage the group climate, tasks, and process; and maintain a purposeful direction and methodology. Such ability is essential, since the trainer has relationships with each member of the group as well as with the group as a whole.

Access to resources is particularly essential for beginning trainers, but important to all trainers regardless of experience. At one time or another, we all need someone to turn to for help in processing our experiences.

Furthermore, the trainer must be functioning at a high level of facilitative effectiveness. Research by Carkhuff (1969), Aspy (1972), Leiberman, Yalom, et al. (1973), and others has indicated that trainees gain more from trainers whose functioning is high. Conversely, the functioning levels of trainees tend to deteriorate or show no increase beyond an entry level with trainers whose functioning is low. The implication is that trainers who cannot perform adequately in human interactions cannot teach others to perform adequately. In behavioral terms, this means that the trainer as a teacher must be able to model the skills he is teaching.

The effective trainer demonstrates competence, confidence, enthusiasm, spontaneity, flexibility, innovativeness, creativity, an ability to seek help when needed, receptivity to feedback and input from his trainees, and a willingness to learn from what he teaches. Even though the training model is systematic and structured, it is not a completely self-instructional programmed learning model. It is the trainer as a high level functioning human being who makes it work.

LEARNING ACTIVITIES

The course is basically experiential and occurs primarily in small groups. Each major concept that is introduced is described in a brief mini-lecture discussion and has explanations with written practice examples in the *Training Manual for Counseling Skills*. Participants learn to recognize and differentiate facilitative and nonfacilitative counselor responses through exercises using a prerecorded stimulus tape and structured rating scales. Participants then write their own responses to prerecorded client statements. Finally, participants integrate and practice counseling skills in paired interactions with one another. This process is called Interpersonal Process Recall and allows each individual to (1) experience the impact of the helping tools he has learned, (2) incorporate his own style into his responses using new skills, and (3) receive specific feedback about his strengths and weaknesses as a helper. The interactions are either audio- or videotaped for the purpose of the recall. The activities are described in more detail in the section that follows.

COURSE MATERIALS

Trainer's Manual:	course background information and guidelines for course delivery
Training Manual for Counseling Skills:	explanations and exercises for each skill area being learned
Audiotape:	prerecorded client statements and counselor responses for use in skill-building exercises
Evaluation Instruments:	pre- and posttests and guidelines for test administration and scoring

EVALUATION

The *Counselor Training: Short-term Client Systems* course has been delivered through the National Institute on Drug Abuse (NIDA) supported National Training System since January 1973. Since that time, extensive evaluation of the course has included objective testing of participant learning and skill acquisition through pre- and posttest procedures; random sampling of persons in programs where the course has been delivered; evaluation of participant satisfaction with the course; and a doctoral dissertation comparing the training results within a population of university peer counselors and federal employees having counseling responsibilities with counseling center staff.

Over time, the evaluation procedures used have changed from the originally cumbersome and complex system of rating participant responses in a tape recorded simulated counseling interaction to the rating of participant responses to written client statements. (No significant differences were found between the two methods.) In all cases, when the conditions of training were consistent with the requirements outlined in this manual (trainer qualifications, course structure, etc.) significant changes in the trainee skills were documented. Ratings based on the participants' overall satisfaction with the course have been recorded consistently at between 4 and 5 (on a scale where "1" is low and "5" is high).

The response to the course in the field has also been positive. UCLA and Michigan State University have offered this course for credit. Some states are using the course to meet credentialing requirements. Many treatment programs have adopted the course for training their paid and volunteer staff. Over 20,000 copies of the course materials have been distributed since it was made available to the public.

There are not many significant differences in the characteristics of the various training populations: 50 percent of the trainees have been male, 50 percent female; approximately 60 percent of the trainees have had at least a B.A. degree, 40 percent have had some college, a high school diploma or less. The average participant has had about one year of counseling experience. Participants have been drawn from almost all the states and have represented countries all over the world.

NOTE: PAGE 760 HAS BEEN DELETED; HOWEVER ALL MATERIAL HAS BEEN INCLUDED.

COMMENTS ON SCHEDULING

The schedule should be regarded as a guideline for time planning, rather than a rigid timetable. The amount of time required for individual small groups to complete a given module will vary. More time may be spent on one, less time on another. However, the trainer must continually be aware of the amount of material to be covered in relation to the amount of time available.

If, due to limitations in time, staff, facilities, etc., a schedule other than the three mentioned must be chosen, the following guidelines are suggested:

- Sessions should not be less than 3 hours.
- There should not be fewer than 2 sessions per week (either 2 half days per week, or 1 full day per week).
- The sequence of events must be maintained.

If the total time available for training does not allow for the presentation of all modules in their entirety, the following information should be considered:

- The time designated for IPR Practice is the most important part of the training. It provides the trainees with the opportunity to integrate and actually practice the previously discussed skills, explore their uses and receive feedback on their performance as a listener/helper. Therefore, it is important that these modules not be drastically shortened or omitted.
- The problem-solving section of the counseling skills training is that which is least in need of a trainer's management. Therefore, the amount of time actually spent on this module can be less than what is scheduled. If the process itself is clearly presented, trainees can continue its practice on their own.

COURSE SCHEDULE

TIME		ACTIVITY	GROUP SIZE
3 hours	**UNIT I:**	**COURSE INTRODUCTION AND OVERVIEW**	
(1 hour)	Module 1:	Large Group Introduction and Pretesting	Large
(45 minutes)	Module 2:	Ice Breakers	Large
(15 minutes)	Module 3:	Introduction to the Helping Relationship	Large
(1 hour)	Module 4:	Small Group Introduction and Norm Setting	Small
18 hours	**UNIT II:**	**EMPATHY**	
(30 minutes)	Module 5:	Definitions	Small
(1½ hours)	Module 6:	Owning of Feelings	Small
(2 hours)	Module 7:	Responding to Feelings	Small
(1½ hours)	Module 8:	Specific Labeling of Feelings and Sources	Small
(1½ hours)	Module 9:	Responding to Feelings in Conflict	Small
(2½ hours)	Module 10:	Owning of Listener Feelings	Small
(8½ hours)	Module 11:	IPR: Interpersonal Process Recall	Small
6 hours	**UNIT III:**	**ATTITUDES AND VALUES**	
(1 hour)	Module 12:	Attitudes	Small
(2 hours)	Module 13:	Values	Small
(3 hours)	Module 14:	Interpersonal Process Recall (Part II)	Small
6 hours	**UNIT IV:**	**PROBLEM SOLVING**	
(5 hours)	Module 15:	Problem Solving	Small
(1 hour)		Posttest	Large

33 HOURS TOTAL TIME REQUIRED

FIVE-DAY SCHEDULE

	Morning 8:30 - 12:00	Afternoon 1:00 - 4:30
Day 1	Course Introduction and Overview and Pretesting Definitions (Modules 1 - 5)	Owning of Feelings Responding to Feelings (Modules 6 - 7)
Day 2	Specific Labeling of Feelings Responding to Feelings in Conflict (Modules 8 - 9)	Owning of Listener Feelings Interpersonal Process Recall (Modules 10 - 11)
Day 3	Interpersonal Process Recall (Module 11)	Interpersonal Process Recall (Module 11)
Day 4	Attitudes Responding to Values (Modules 12 - 13)	Interpersonal Process Recall (Module 14)
Day 5	Problem Solving (Module 15)	Problem Solving Posttest (Module 15)

IN-SERVICE TRAINING SCHEDULE

The above schedule may be taken in 3½ hour blocks of time and conducted in 10 in-service training sessions over a period of 5 weeks with 2 sessions per week.

TWO WEEKEND SCHEDULE

First Weekend

	Morning 9:00 - 12:00	Afternoon 1:30 - 4:30	Evening 7:00 - 10:00
Friday			Introduction Overview Pretest
Saturday	Small Group Introduction and Definitions Owning of Feelings	Responding to Feelings Specific Labeling of Feelings and Sources	Responding to Feelings in Conflict Owning of Listener Feelings
Sunday	Empathy Practice IPR	Empathy Practice IPR	Empathy Practice IPR

Second Weekend

Saturday	Review Empathy Skills Responding to Values and Attitudes	Responding to Values Practice	Responding to Values Practice IPR
Sunday	Problem Solving	Problem Solving	Posttest

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CHAPTER TWO

WORKBOOK FOR COUNSELING SKILLS

INTRODUCTION

As you use this manual, you will be learning a set of skills and tools that will aid in developing the helping relationship. You may be refamiliarizing yourself with skills that you already possess, but we ask that you try out this set of skills, as instructed, so that you can practice and receive feedback on your knowledge and use of this model.

As the pace of life around us accelerates, we tend to become increasingly lost in facts and ideas; the level of feelings is often ignored. Our terms of interaction are "I agree" or "I disagree." "I understand," however, is a statement rarely heard. This attempt to understand another person seems to require something very basic: that is, a desire to understand and an expression of that desire. We are assuming that you, as a person, do care. The program in which you are about to engage is designed to facilitate your effectiveness as a helper, to translate your concern into constructive action.

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UNIT I

COURSE INTRODUCTION AND OVERVIEW

INTRODUCTION

Unit I is designed to acquaint you with each other and with the training environment, and to introduce the course content and methodology; it also includes registration and pretesting. There are four modules in this unit:

- Module I: Large Group Introduction and Pretesting
- Module 2: Ice Breakers
- Module 3: Introduction to the Helping Relationship
- Module 4: Small Group Introduction and Norm Setting

Unit I will require about 3 hours to complete.

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MODULE 1

LARGE GROUP INTRODUCTION AND PRETESTING

The purpose of this module is to orient you to the training environment (e.g. places to eat, park, get messages, etc.) and to complete registration and pretest procedures.

The purpose of the pretest (and posttest) is to provide the trainers with feedback on their ability to *impart skills*—the tests are not meant to be used as evaluations of the trainees. Test scores are given only to those participants requesting their own scores; they are not given to supervisors.

The following space may be used to record any necessary information.

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MODULE 2

ICE BREAKERS

The activities that will be conducted by the trainer during this module will help you become acquainted with the other participants in the training program, and will serve to identify them as possible future resources.

In this module, all that is necessary is to follow the trainer's instructions.

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MODULE 3

INTRODUCTION TO THE HELPING RELATIONSHIP

The purpose of this module is to acquaint you with the schedule for the course, the content areas to be addressed, and the process by which the skills will be learned. A small amount of theory pertaining to the helping relationship and its relevance to a concept of the whole person will be presented. The small groups will also be formed at this time.

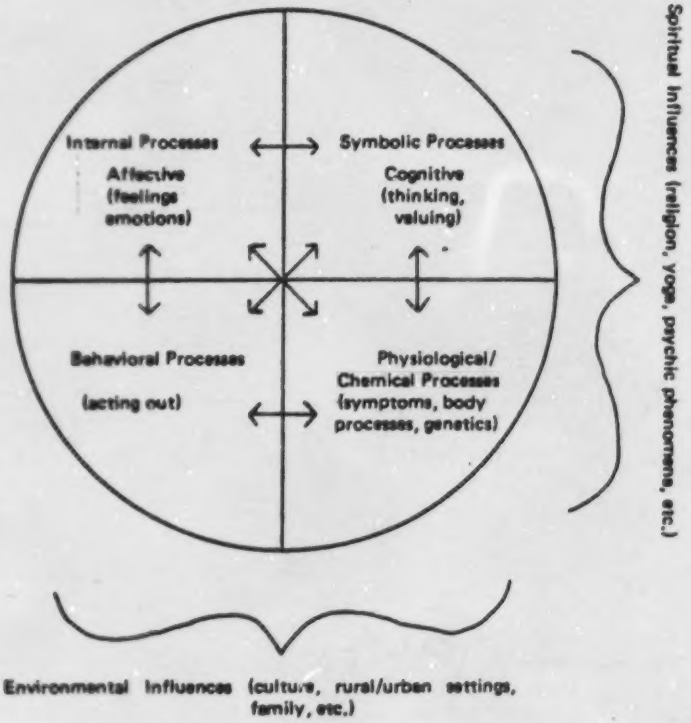

Figure 1

The helping relationship consists of a speaker (the person presenting the problem) and a listener (the person acting as helper). The ultimate goal of the helper is to enable the speaker to reach his own decision concerning a course of action that will solve the problem. The entire helping process has three stages. The first involves empathic listening and communication to help the speaker get in touch with his *feelings*.

Secondly, the listener helps the speaker integrate his feelings about the problem with his *thinking* about it: he helps the speaker to consider it with his own values and attitudes.

Thirdly, the listener helps the speaker integrate his feelings and values into a problem-solving process: he helps the speaker decide *what* to do about the problem and explores with him *how* to go about doing it. Although the stages are not mutually exclusive, (two or more of the stages may occur at the same time in the interaction) their division into steps may help clarify some of the complex events you will participate in as a helper. A complete helping relationship would consist of this entire process, but a speaker may need help from a listener only for parts of the process. Remember, a person needs to learn to solve his own problems.

Graphically, the helping relationship looks like this:

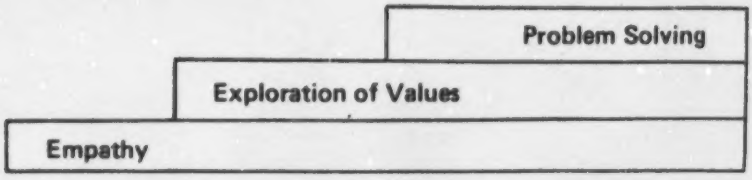

Figure 2

EMPATHY

Being asked to help someone with a serious problem can often be overwhelming. The helper should start by listening and responding to feelings. This is empathy, and the emphasis is on feelings.

Feelings are often distrusted and usually relegated to the shadowy parts of ourselves. We learn that we should not feel anger, that we should learn to strive for emotional control, and that those who lose that control are weak. Yet, we know that feelings are real. We know that they are part of our physical existence and that they cannot be wished away. We know also that feelings, however much they are ignored and distrusted and trampled upon, will certainly affect our behavior.

A person with a problem has feelings, many of which are hidden away. The helper's job is to enable that person to discover and understand these feelings. To rectify a problem a person must first understand his own feelings about it. Then and only then does it make sense to decide on a course of action designed to solve the problem.

Empathy, the listener's understanding response to the feelings of the speaker, is important because it allows the speaker to feel safe and accepted, not judged or condemned because of his feelings. When you as helper respond to a speaker empathically, that person will feel comfortable, and will be motivated to continue talking to you and to further explore his own feelings with you. As you facilitate both your own and the speaker's understanding of

his feelings, you build trust and help the speaker better comprehend his problem. You will be learning to *listen*, to *understand*, and to *communicate*.

- **It is not enough to listen unless you understand what you've heard.**
- **It is of little use to understand unless you communicate that understanding.**
- **The communication is useful only if the information can be applied by the other person to his decision-making process.**

VALUES

After you have begun to help a speaker clarify his feelings about a problem, you will also want to explore the speaker's thoughts about his problem. You will again be listening, understanding, and communicating, but your focus will be on the aspects of the problem the speaker sees as positive (rewarding) and those he sees as negative (punishing). The speaker's values will also play a part in his decision-making process.

PROBLEM SOLVING

Once you have helped the speaker clarify his feelings and values and attitudes, he is ready to explore alternatives and solutions to his problem. You can assist this process by understanding that decision making can be effectively accomplished according to a set of guidelines that also incorporates empathic communication. You will learn to help the speaker clarify his problem, explore alternatives, plan strategies for change, and test alternatives.

SUMMARY

Feelings are the common ground, values are the basis for patterns of behavior, and problem solving offers a process for resolution. The key to the entire helping relationship is to remember that you are trying to facilitate the speaker's understanding of his problem and himself so that in the future he will be able to apply to new situations what he has learned from this experience.

In the training pages ahead, our cast of characters (speakers, listeners, givers and receivers of feedback) will look like this:

. . .and like this

MODULE 4

SMALL GROUP INTRODUCTION AND NORM SETTING

ADDITIONAL SKILLS

The course offers *additional* counseling skills; it is not a dogma or catechism of counseling skills.

- The skills you already possess will still be effective when appropriately used. The *CT:STCS* course offers more skills—additional tools to draw upon; it does not necessarily replace other techniques, tools, etc.

- The most effective way for you to learn new tools is to set aside your old ones. Attempting to integrate new skills before they are completely understood and practiced often leads to confusion and frustration, and slows the learning process. Once the new skills are thoroughly acquired, integration can occur.

SKILL BUILDING

The course is designed to build counseling skills; it is not personal therapy for participants.

EXPERIENTIAL LEARNING

The course for the most part is experiential.

- The training program is built on the premise that counselors will not learn to make more helpful, effective responses by simply *knowing* what should be done; they must also be able to do it. This practice will also give you a chance to experience your impact on others, and others' impact on you.

- Training aids include taped discrimination exercises, and videotapes for use during feedback (Interpersonal Process Recall).

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SYSTEM OF LEARNING

The course is structured, *systematic and sequenced*. It follows a critical path that creates a *cumulative acquisition of skills in successive approximation* to the tasks required in the real work environment.

- The sequence of concepts presented in training is as follows:

  Listening

  Understanding

  Awareness of the bilateral nature of the counseling relationship

  Problem solving

- Each step must be completed before moving to the next; each skill is built upon the skill preceding it.

- The cumulative acquisition of skills allows time for evaluation of skill acquisition so that prerequisite skills can be identified and strengthened if necessary. Small steps are incorporated not only in the sequencing of concepts and skills, but also in the tasks required of the learner (successive approximation).

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FEEDBACK IN THE SMALL GROUPS

Feedback is a way of helping another person or ourselves consider changing some aspect of behavior. It is a communication to a person that gives him information about his behavior and its effect on others. Feedback lets someone know whether or not his behavior is having the effect he intended; it tells him whether he is on target or not as he strives to achieve his goals. Good feedback can either confirm behavior by encouraging repetition, or correct it by encouraging a change in behavior to fit the situation.

Feedback is a message we get from others. It can be verbal or nonverbal, but it is always a signal—a smile, a clenched fist, a facial expression, a body posture, a mutter, a specific word—that tells us how we have affected others.

Feedback between you and your fellow group members in this training will be your most valuable learning tool. You need each other to learn. You are both trainee and trainer—not only receiving feedback from other group members about your behavior and skills, but also giving it to them when it's appropriate. You are each other's resource people. Try to give feedback as often as appropriate and feel free to ask for feedback yourself.

Feedback can be helpful or destructive, useful or useless, depending upon how and when it is given. You will be more effective as a resource person if you learn and follow some general rules for giving helpful feedback. Remember that constructive feedback doesn't refer only to positive aspects of a person's behavior or to what we liked about something someone did. Good feedback covers both positive and negative qualities, things we liked and disliked, behavior a person may want to keep and behavior he may want to consider changing.

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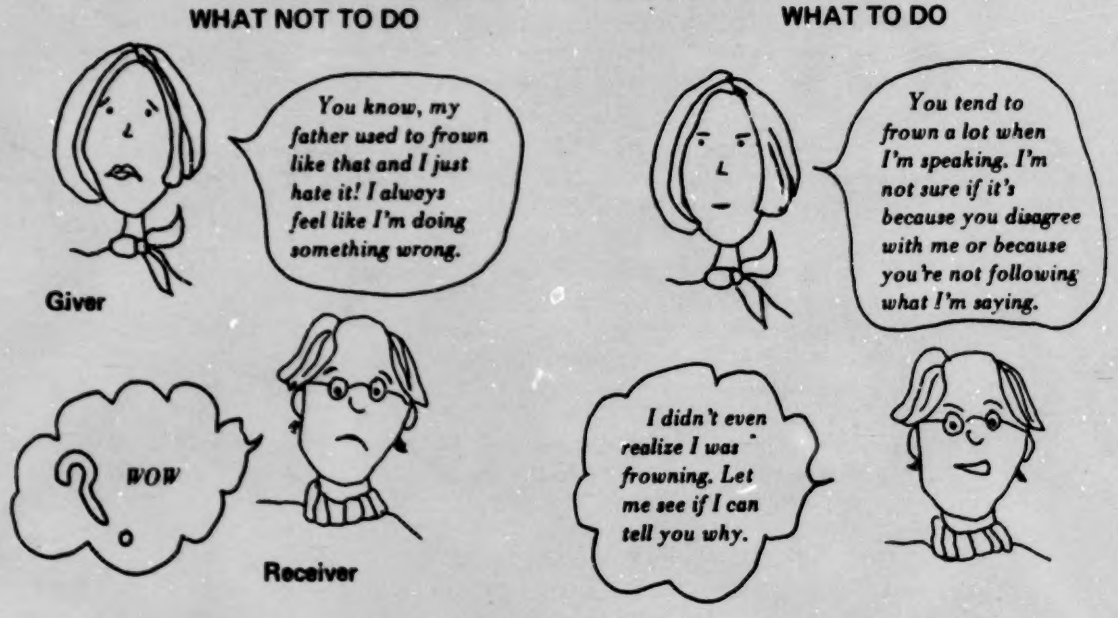
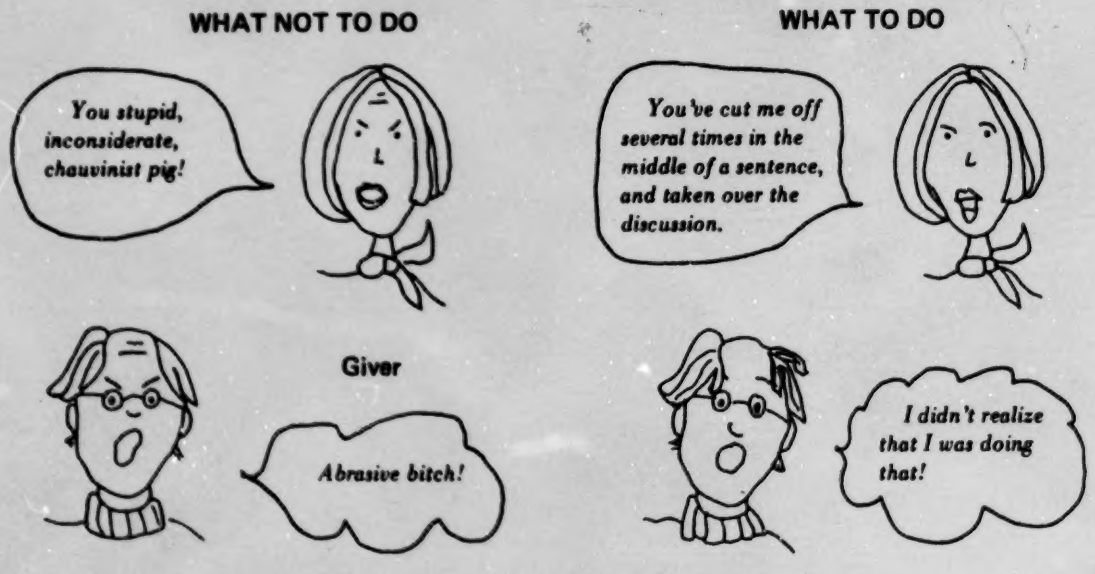
GUIDELINES FOR FEEDBACK IN THE SMALL GROUPS

1. Give feedback that is intended to help the receiver; do not "dump" or "unload" on someone just to have something to say.


WHAT NOT TO DO
WHAT TO DO
You know, my father used to frown like that and I just hate it! I always feel like I'm doing something wrong.
You tend to frown a lot when I'm speaking. I'm not sure if it's because you disagree with me or because you're not following what I'm saying.
Giver
WOW
I didn't even realize I was frowning. Let me see if I can tell you why.
Receiver

2. Give feedback that describes what the person is doing; do not evaluate him as a person.


WHAT NOT TO DO
WHAT TO DO
You stupid, inconsiderate, chauvinist pig!
You've cut me off several times in the middle of a sentence, and taken over the discussion.
Giver
Abrasive bitch!
I didn't realize that I was doing that!
Receiver

3. Give feedback that is *specific*, with clear and recent examples; do not be vague or general.

WHAT NOT TO DO

WHAT TO DO

I especially liked the way you picked up on the anger in that person's voice just now.
He must have heard some anger too. I think I did the right thing.

4. Give feedback that is *well-timed*, as soon after the behavior as possible; do not give feedback if the receiver doesn't seem ready to hear it.

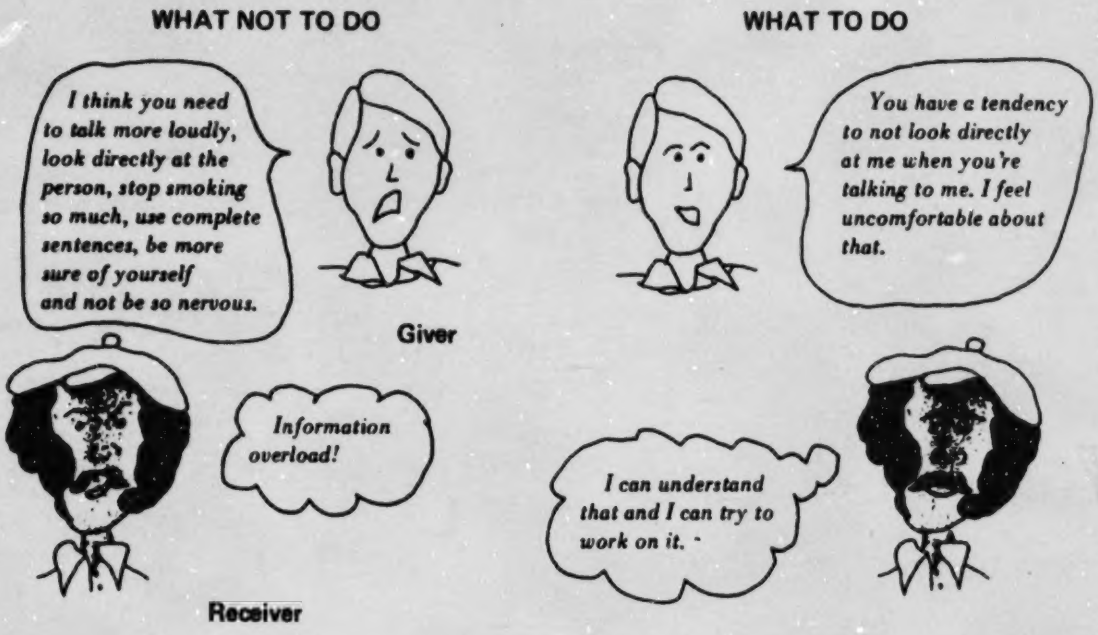
WHAT NOT TO DO

I can see that you're crying and in pain, but why don't you explain why you did that again.
Giver
I can't talk now, can't he see that?
Receiver

WHAT TO DO

Wait until the receiver can hear or accept the feedback.

5. Give feedback in *appropriate doses*. Do not give more than the receiver can process at one time.


WHAT NOT TO DO
WHAT TO DO
I think you need to talk more loudly, look directly at the person, stop smoking so much, use complete sentences, be more sure of yourself and not be so nervous.
You have a tendency to not look directly at me when you're talking to me. I feel uncomfortable about that.
Giver
Information overload!
I can understand that and I can try to work on it.
Receiver

6. Give feedback that is directed toward behavior that the receiver can *reasonably* be expected to do something about.

WHAT NOT TO DO
WHAT TO DO
Your soft voice irritates me, I wish you didn't have it.
You speak very softly and it is hard to hear you. Could you talk a little louder?
Giver
I can't do anything about it!
I can understand that and I can try to work on it.
Receiver

7. Give feedback that can be *checked with the receiver* to ensure clear communication.

WHAT NOT TO DO

WHAT TO DO

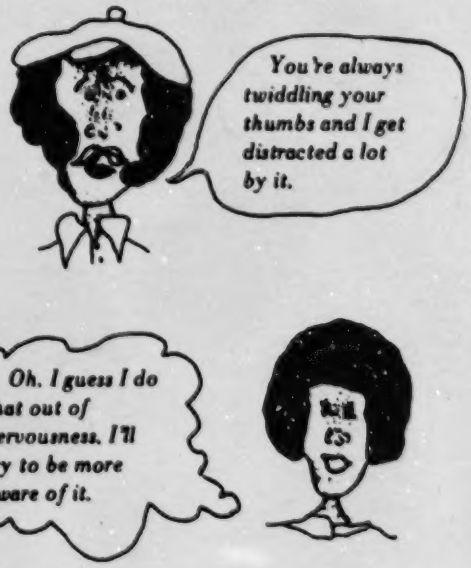
You tend to jump around from one idea to another and I'm having trouble following you. Could you paraphrase that for me so I know that you understand?
You say I skip around a lot and you can't follow me.

8. Give feedback describing the *effect* that the receiver's behavior has on you. *Avoid asking "why?"*

WHAT NOT TO DO

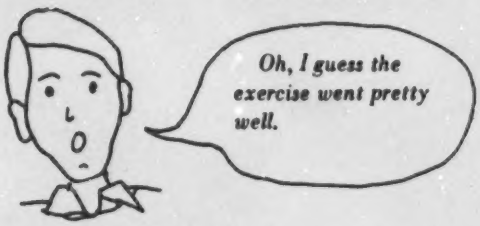
You're always twiddling your thumbs. Why in the world do you keep doing that?
Gee, I don't know. It's just something I do.
Giver
Receiver

WHAT TO DO

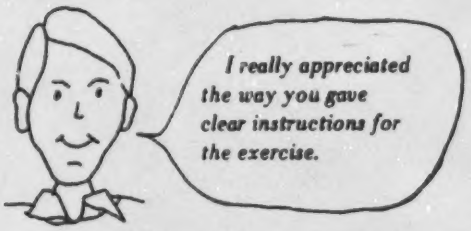

You're always twiddling your thumbs and I get distracted a lot by it.
Oh. I guess I do that out of nervousness. I'll try to be more aware of it.

9. Give feedback *directly* and with real feeling.

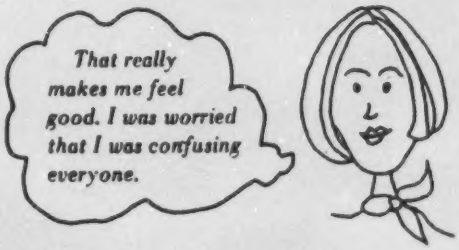
WHAT NOT TO DO



WHAT TO DO



Giver



Receiver

10. Give feedback that can be checked with the group for accuracy and validity.

This one is hard to draw. It means that you gather as many opinions as possible to help determine if the feedback is appropriate and useful.

UNIT II

EMPATHY

INTRODUCTION

Unit II is designed to improve your ability to (1) listen and hear the message being communicated by a speaker (client); (2) understand that message in terms of both the stated and the implied feelings and the sources of those feelings; and (3) respond to the stated and implied feelings.

The unit also includes a module in which you will examine your own feelings when interacting with a client and explore how those feelings can both impede and facilitate the helping process.

Empathy skills will be imparted through a series of structured exercises and practiced in speaker/listener role plays.

There are seven modules in Unit II:

- Module 5: Definitions
- Module 6: Owning of Feelings
- Module 7: Responding to Feelings
- Module 8: Specific Labeling of Feelings and Sources
- Module 9: Responding to Feelings in Conflict
- Module 10: Owning of Listener Feelings
- Module 11: Interpersonal Process Recall

This unit will require about 18 hours to complete.

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MODULE 5

DEFINITIONS

In this first section of the training program we will focus on one way people respond to the world they live in, namely with *feelings* or *affect*. Both words mean the same thing. In order to look at feelings, it is important that we define some of the concepts people often confuse with feelings, such as "situations," "symptoms," and "sources." Throughout this manual, terms will be defined as they are intended for use within this training model.

Definition 1 *Situations* are the events, settings, times, places, and people that make up an experience or story.

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Definition 2 *Symptoms* are the physiological responses (i.e., things your body does) or behaviors that are your nonverbal reactions to a situation.

You smile.

You cry.

Your mouth hangs open.

Your stomach has butterflies.

Your heart beats hard.

Can you think of some more? (You don't have to draw them.) Share the list with your group and expand your own list from input made by other group members.

Definition 3 *Feelings* are the emotions that are experienced by us in a given situation, and that we describe with word labels.

Thus labeled, we have a feeling, and we can react to that feeling, understand it, examine it, and try to change it if we wish.

Situation:
You've just been given a present.

Symptom:
It makes you smile.

Feeling:
It makes you feel happy.

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A few more feeling labels are: angry, sad, disappointed, excited. Can you think of others? Take time in your group to have each person make a list of "feeling" words. Put a plus (+) beside each positive feeling word and a minus (-) beside each negative word. Then share your list with your group. Make your list of "feeling" words (labels) here:

Now that we know about feelings, we can consider where they come from.

Definition 4 *Sources* are the concerns, situations, or persons that have stimulated the feeling.

Our feelings are a response or reaction to something in our experience. We don't just suddenly and for no reason have a feeling walking down the street; feelings have sources. It is just as important to recognize what those sources are as it is to know that we have feelings.

If you think you see a similarity between "sources" and "situations," you are right. Our feelings can be caused by (1) events, places, people, or other things outside ourselves, or (2) by something inside ourselves, such as physical discomfort or pleasure, fantasies, or even another feeling! Have you ever felt selfish and then felt guilty about feeling that way?

Let's look again at our happy friend and examine the source of her feelings.

Situation:
She has just been given a gift.

Symptom:
She smiles.

Feeling:
She feels happy.

Source:
Someone gave her a present.

The following Self-Examination Example (S.E.E.) may be used to check your understanding of the terms just defined (The answers that you give and the answers provided in this manual should be thought of as "appropriate" rather than "correct.")

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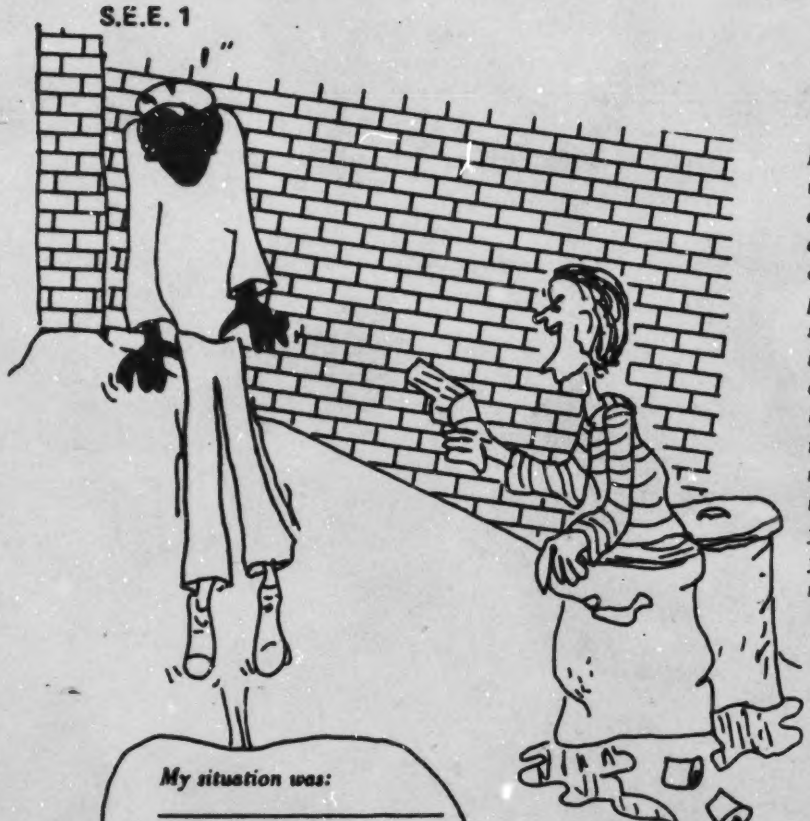
S.E.E. 1



I was walking home last night and I decided to take a short cut through the alley. It was dark and cloudy, so I was walking pretty fast, when all of a sudden this guy popped out in front of me. Man, did I ever jump! My heart was beating away and I started to sweat. Then he said in a really mean voice, "Hold it right there! Hand me your wallet, or I'll blow your brains out!" I was really terrified.

My situation was:

My symptoms were:

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I felt:

The source of my feelings was:

S.E.E. 1 ANSWERS

Situation:	**nighttime, alley, robbery, etc.**
Symptoms:	**jumping, heart thumping, sweating, etc.**
Feelings:	**terrified, scared, frightened, etc.**
Source:	**being robbed, getting shot, fantasizing about being killed, etc.**

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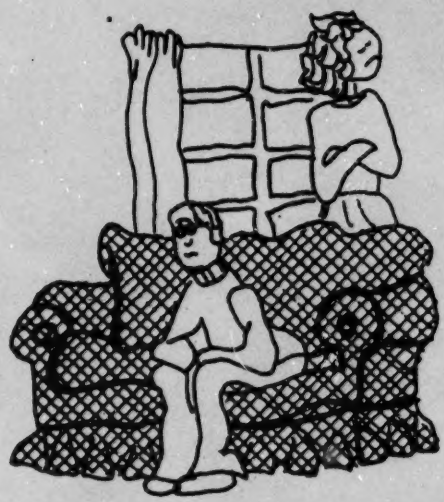
S.E.E. 2

My girlfriend and I had a fight last night about her seeing other guys. I was trying to understand but my stomach was just tied in knots. There were a couple of times I thought I was gonna throw up. It felt like I was getting pulled in two directions at once. Part of me was really hurt by the thought of losing her and part of me was confused about what to do.



My situation was:

My symptoms were:

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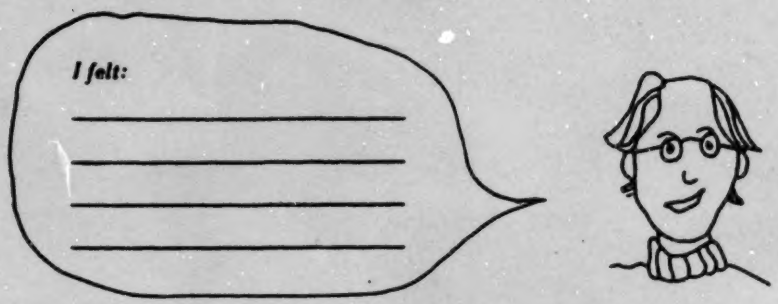

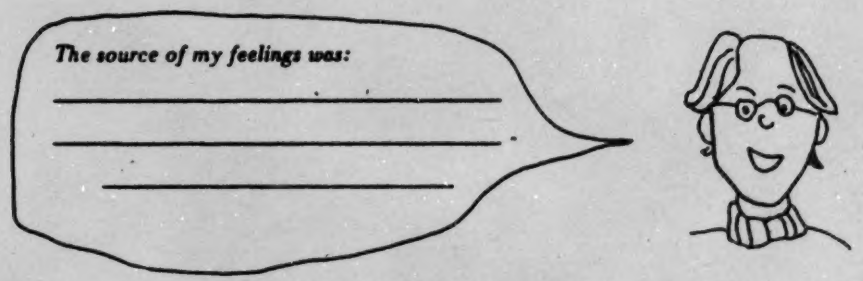

S.E.E. 2 ANSWERS

Situation:	my girlfriend told me she wants to date other guys
Symptoms:	stomach in knots, nauseous, being pulled two directions
Feelings:	hurt, confused, angry, rejected, worried, etc.
Source:	the idea of losing my girlfirend, wanting to understand and do the right thing

MODULE 6

OWNING OF FEELINGS

The first step in the helping relationship is to help the speaker clarify and explore how he feels about his problem. We have already discussed how feelings are interwoven with our total experience—feelings affect behavior and are, in turn, affected by the situations in which we find ourselves. If a person comes to you for help, it is probably because he is having a problem and is experiencing some generally bad feelings about it. Helping him understand his feelings and how they are connected to his problem will eventually give him the freedom to make decisions that will make him feel better. In order to accomplish this first step, the helper must "tune in" well enough to the speaker's communication to be able to sort out the meaning from the story, the feelings from the facts. The helper must learn to be a true *listener.*

There's another important reason for learning to listen for the speaker's expression of feelings. The listener can't begin to help a speaker understand, sort out, and deal with his feelings if the speaker doesn't know he's experiencing feelings, or even denies having feelings at all. Your first real task as a listener may be to help the speaker to recognize and then accept his feelings. On the other hand, if the speaker is already aware of his feelings and what is causing them, you won't have to spend lots of time helping him get in touch with what's going on. You can begin helping him clarify, explore, and understand his feelings.

Your first job as a listener during the *empathy* phase of the helping relationship is to listen carefully to the feelings that the speaker is expressing, in order to determine how well he is owning them. *Owning feelings* is the extent to which the speaker—

- recognizes and expresses verbally (uses word labels for) his immediate feelings;
- describes where his feelings come from;
- accepts ownership and responsibility for his feelings.

In order to assess how much a speaker is owning feelings, it is essential to have a clear idea of what it sounds like when someone *is* or *is not* owning feelings. Also, it's important to practice listening to the expression of feelings without thinking about solutions or advice or what to say next.

We think it will help to learn these skills through a training aid called a "scale." After reading the following scale and listening carefully to some taped examples of a speaker's statements, you should be able to determine which speaker will need the most help in getting in touch with his feelings.

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OWNING-OF-FEELINGS SCALE

LEVEL ONE: The speaker does not own his own feelings by—

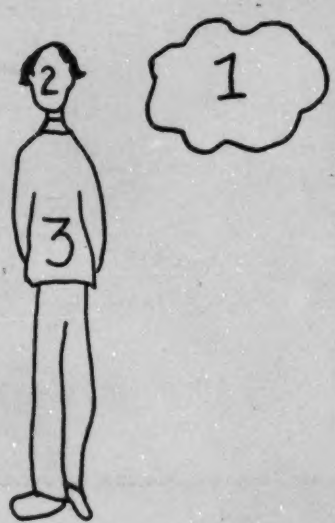
- *denying* his feelings or *avoiding* discussion of them;
- *detaching* himself from his feelings, and describing them as though they are not part of himself but come from outside himself, or are forced on him by other people or situations;
- *minimizing* feelings or talking about them in an abstract or superficial manner.

LEVEL TWO: The speaker attempts to own his feelings by—

- describing his feelings in a *vague* manner, or *distancing* them by using past or future terms;
- acknowledging his feelings but discussing them in an *intellectual* or *philosophical* manner;
- stating his feelings *without* clearly linking them to a *source*.

LEVEL THREE: The speaker owns and takes responsibility for his own feelings by—

- identifying his immediate (here and now) feelings *clearly* and *genuinely*;
- expressing the *intensity* of his feelings;
- specifying the *source* of his feelings.



Briefly,

Level 1 is "out there in the ozone."

Level 2 is a "head trip."

Level 3 is "gut level."

Now that you have studied the scale of feelings, try another self-examination example to check your understanding of this section.

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S.E.E. 3

For each of these statements, check the appropriate level of owning of feelings.

Statement 1

My girlfriend and I broke up last week. We'd been going together for almost two years, and then she met some other guy. I think she was looking for kicks or something. I really don't care though. I'm not going to let it bother me.

Check one:

Level 1 _____

Level 2 _____

Level 3 _____

Statement 2

I'm really depressed about my girlfriend's breaking up with me last week. It hurt me a lot. She dropped me for another guy. I'm really angry at her for deserting me that way. It makes me feel like I'm inadequate.

Check one:

Level 1 _____

Level 2 _____

Level 3 _____

Statement 3

I was bummed last week over my girlfriend. We'd been pretty close for over two years, then she starts seeing someone else. But I suppose that breaking up, even though it hurt at the time, is better than staying with someone you'll always be fighting with.

Check one:

Level 1 _____

Level 2 _____

Level 3 _____

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S.E.E. 3 ANSWERS

1. This is a Level One. The speaker denies having any feelings about his break-up, for example, "I really don't care though." He even detaches feelings further by saying, "I'm not going to let it bother me," as though his feelings were a salesman he could close the door on.

2. This is a Level Three. The speaker clearly identifies his here and now feelings; for example, he uses the feeling labels "hurt," "depressed," "angry," and "inadequate." He also specifies the source of his feelings, "my girlfriend's breaking up with me" and "deserting me that way."

3. This is a Level Two. The speaker describes his feelings vaguely ("bummed"), distances his feelings by saying "was bummed" and "it hurt at the time," and then intellectualizes his feelings by saying, "breaking up is better than staying with someone you'll always be fighting with."

Taped Exercise

Now, let's practice applying the Owning-of-Feelings Scale using the tape recorder. There's one slight difference. Instead of reading the examples, you will listen to them. You can derive a lot of information about the level at which a person is owning his feelings from listening to his voice. Is the voice happy, sad, loud, soft, halting, angry? Actually, an apology is in order, because when you're listening to a tape recorder, you can't look at the person who's talking, and consequently you miss a lot of nonverbal cues (facial expressions, gestures, body postures).

As you listen to the speaker, it will help you assess the owning-of-feelings level if you ask yourself some basic questions about what you have heard. Here is a checklist to use as a guide in your rating:

- What specific feelings did the speaker label?
- Are his feelings something that he sees as part of him, or are they "out there in the ozone"?
- Did the speaker deny feelings, or avoid talking about them?
- Is the speaker minimizing feelings by saying "sort of" or "a little"?
- Is the speaker owning his immediate feelings or is he putting them as far away as possible by talking about them in the past tense?
- What intensity do you hear in the speaker's tone of voice?
- Does the speaker relate his feelings to a source or are they free-floating?
- Does the speaker intellectualize or philosophize about his feelings?
- If the speaker is owning his feelings, are there any other feelings you can detect that aren't being specifically talked about?

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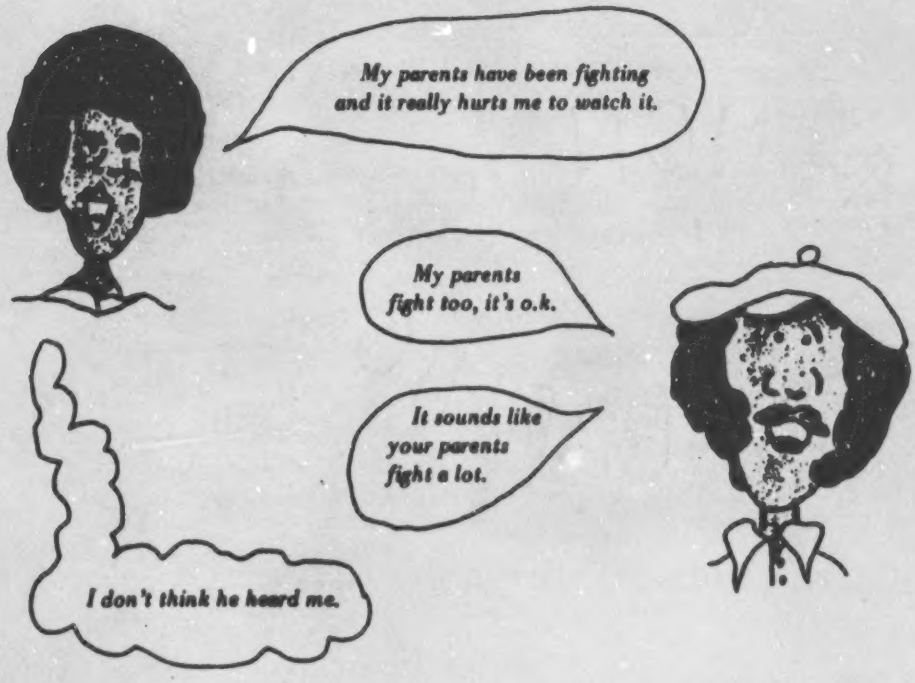
MODULE 7

RESPONDING TO FEELINGS

Now that you've learned and practiced the skill of listening to and understanding what a speaker is saying about his feelings, the next task is to learn how to respond to a speaker's feelings. Remember what was said earlier: *"It is of little use to understand unless you communicate that understanding."*

The first skill to master is discrimination between a listener statement that responds to the speaker's feelings and (1) a listener statement that responds to situational information or facts, (2) a listener statement that is judgmental, and (3) a listener statement that suggests a solution to the speaker's problem.

Definition 5 A *situational response* is any response that responds only to the facts or story of the speaker's situation and ignores the feelings that the speaker is expressing.


My parents have been fighting and it really hurts me to watch it.
My parents fight too, it's o.k.
It sounds like your parents fight a lot.
I don't think he heard me.

In the first response, the listener responds to his own situation, without even considering the speaker's statement. In the second response, he responds only to the speaker's situation.

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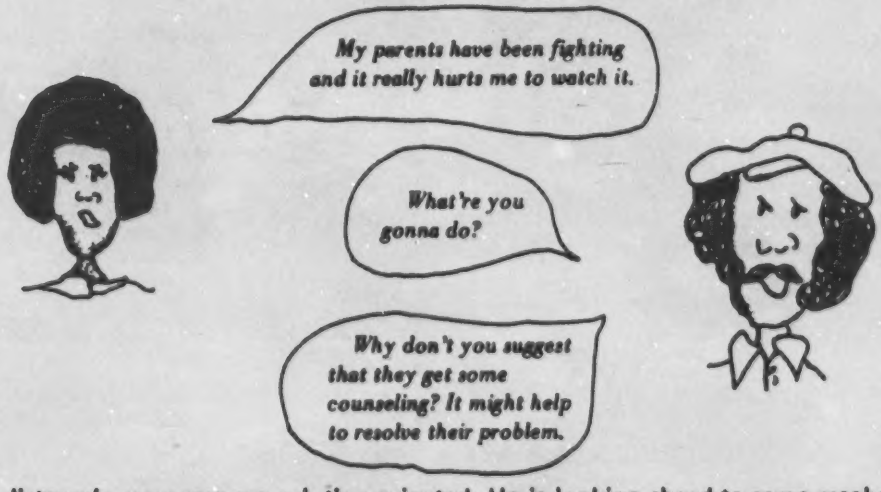
Definition 6 A *judgmental response* is any response that agrees or disagrees with the speaker's feelings, or criticizes the speaker because of his feelings.

My parents have been fighting and it really hurts me to watch it.
You're just too sensitive.
Don't let it bother you. My parents fight too.

In both his responses, the listener criticizes the speaker for having her feelings, as though she's wrong to feel hurt by seeing her parents fight.

Definition 7 A *solution response* is any response in which the listener (1) advises the speaker what to do about his problem, or (2) seeks information from the speaker about what he thinks he should do.


My parents have been fighting and it really hurts me to watch it.
What're you gonna do?
Why don't you suggest that they get some counseling? It might help to resolve their problem.

Both of the listener's responses are solution-oriented. He is looking ahead to some resolution of the speaker's problem, but is missing her immediate pain.

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Solution alternatives are part of the problem-solving process, which will be covered later in this manual. Solution-oriented responses are inappropriate now since they do not respond to feelings. Besides, a listener who comes up with a quick solution at this point in the helping relationship may not even be addressing the real issue and may prevent the speaker from reaching it!

STOP

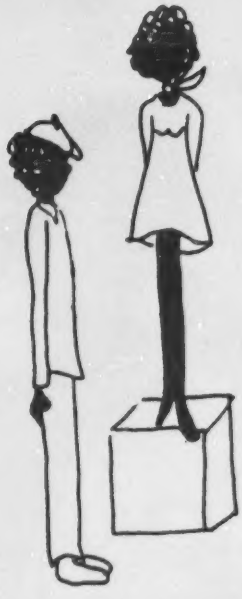
If you want to, go back to Definition 3 and your list of feeling words. It is the *feelings* a speaker presents that are of interest to us in this skill, and it is the listener's response to those feelings that we are now going to concentrate on.

Your primary objective as a listener at this stage is to communicate to the speaker that you heard his feelings, understand them, and accept them. You should communicate in a way that allows the speaker to *own* his feelings: that is, accept them as valid, understand them, and deal with them.

Definition 8

A *sympathetic response* is a response in which the listener communicates to the speaker that he feels sorry for him. A response that says "Aw gee, that's too bad," implies that the speaker cannot do anything about his situation, and that the listener is somehow above the speaker.

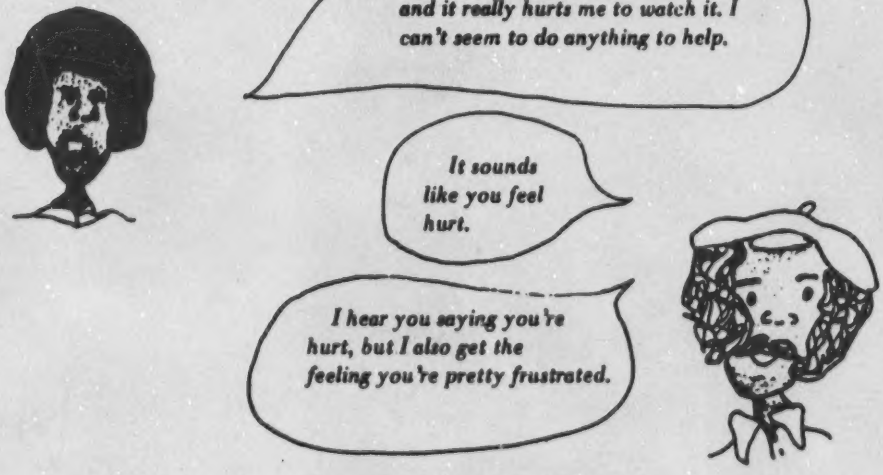
NOTE: This is *not* a helpful response: it does not facilitate the speaker's understanding of and dealing with his feelings.



Defintion 9 An *empathic response* is a response in which the listener communicates to the speaker that he understands, accepts, and can relate to the speaker's feelings. Responding in this way places the listener and the speaker in equal, sharing roles.

NOTE: This *is* a helpful response: it facilitates the speaker's understanding of and dealing with his feelings, and also helps to build trust. The speaker knows the listener cares about his feelings.

Definition 10 *Responding to feelings* is the process whereby the listener hears the speaker's feelings and gives them back in a positive reflective statement that lets the speaker know that the listener has heard his feelings. He "mirrors" what he has heard.


My parents have been fighting and it really hurts me to watch it. I can't seem to do anything to help.
It sounds like you feel hurt.
I hear you saying you're hurt, but I also get the feeling you're pretty frustrated.

Both responses are positive reflective statements.

1. Positive reflective statements can bring the speaker's vaguely expressed feelings into clearer focus. They can even help the speaker's owning of feelings by enabling him to hear the feelings he has expressed and to recognize them as his own.

2. Some ways of starting a positive reflective statement are: "I hear your. . .," "I hear you saying. . .," "It sounds like you. . .," "What I'm hearing is. . .," "You sound. . .," etc.

3. Note that the listener could have said, "That must be painful for you,"—showing he has really *heard* her by being able to match "hurt" with another label.

In the first response, the listener has mirrored the speaker's feeling label "hurt." In the second, he is also picking up a feeling the speaker is not stating with specific labels, but is implying—"frustration."

Definition 11 — *Undercurrents* are emotions the speaker may be experiencing that he has not yet actually owned—feelings that are still rumbling around in the speaker beneath the surface that he has not yet labeled or even discovered.

In the last example, the second response labeled an undercurrent feeling. Can you go back and find the feeling that fits this description? Being able to detect undercurrents and communicate them back to the speaker is a very useful and facilitative tool. The listener is responding to the total communication of the speaker: what is said and what is implied. It helps the speaker to examine his feelings more clearly and closely. Reflecting undercurrents can also help a speaker who isn't owning his feelings, or who is having trouble doing so.

You can get clues as to what labels to put on these undercurrents by—

1. imagining yourself in the speaker's position and trying to guess what he might be feeling;

2. trying to get a picture of what he is describing and then labeling with "feeling" words what he might be experiencing;

3. paying attention to nonverbal cues and putting labels on those emotions the speaker is showing you but not talking about.

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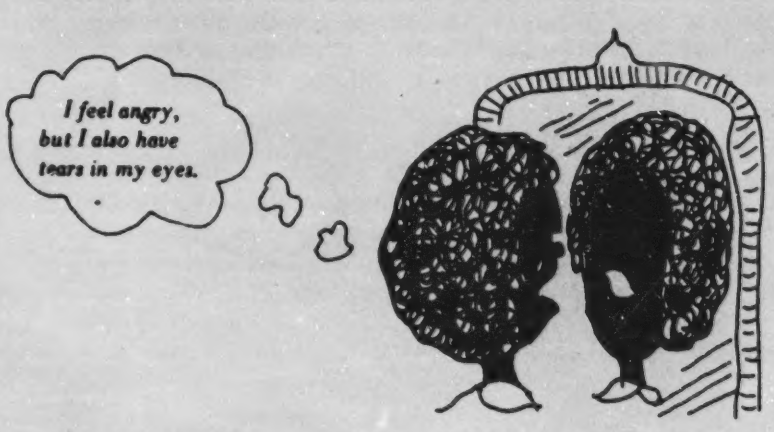
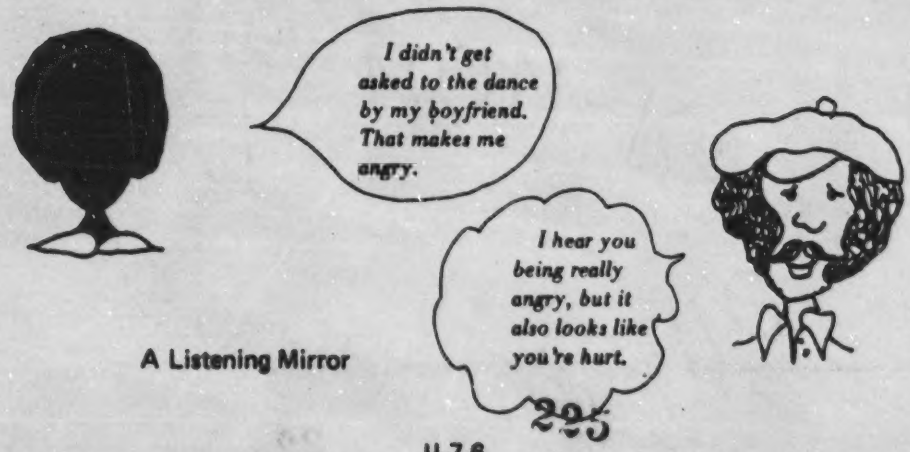
CAUTION: Remember that you as a listener are trying to help the speaker talk about what he is feeling. It is *not* your job to tell the speaker what he should feel, or to tell him what you would feel if you were in his position. Nothing turns a speaker off more quickly than having his own, true feelings taken away from him, or having feelings that aren't his forced on him. When you respond to undercurrent feelings, your positive reflective statement should be clearly tentative to allow the speaker to own or discover those undercurrent feelings. Some ways of checking out undercurrents are to say "I wonder if you're also feeling. . .," "I'm also picking up some. . .," "It seems like there also may be. . .," etc.

Maybe a story will be more helpful. You know how sometimes you walk up to a mirror and look at yourself and say, "Is that really me?" For sure it is. The mirror can't make anything up; it can just reflect what is there. Well, a good listener is like a good mirror. In fact, a good listener is better, because he can give you objective verbal feedback too.



A Regular Mirror


I didn't get asked to the dance by my boyfriend. That makes me angry.
I hear you being really angry, but it also looks like you're hurt.

A Listening Mirror

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Now that you have had all these definitions, more pictures and more wordy explanations, you should have a strong enough foundation to understand the *Responding-to-Feelings (R.T.F.) Scale.*

RESPONDING-TC-FEELINGS SCALE

LEVEL ONE: The listener does not facilitate the speaker by—

- *denying* speaker's feelings, putting them down, ridiculing, *judging*, or offering quick *solutions*;
- responding only to the *facts*, the situation, or the storyline;
- *ignoring* the speaker's *feelings*.

LEVEL TWO: The listener facilitates the speaker by—

- *reflecting* the stated feelings of the speaker, using the same or similar words;
- maintaining nonverbal behavior that is *attentive* to the speaker;
- *accepting* the speaker's feelings by being nonjudgmental.

LEVEL THREE: The listener facilitates the speaker by—

- responding to stated feelings and to *undercurrent* feelings that the speaker has implied but has not clearly stated;
- acknowledging the *intensity* of the speaker's feelings with appropriate nonverbal behavior;
- responding to *nonverbal* cues from the speaker.

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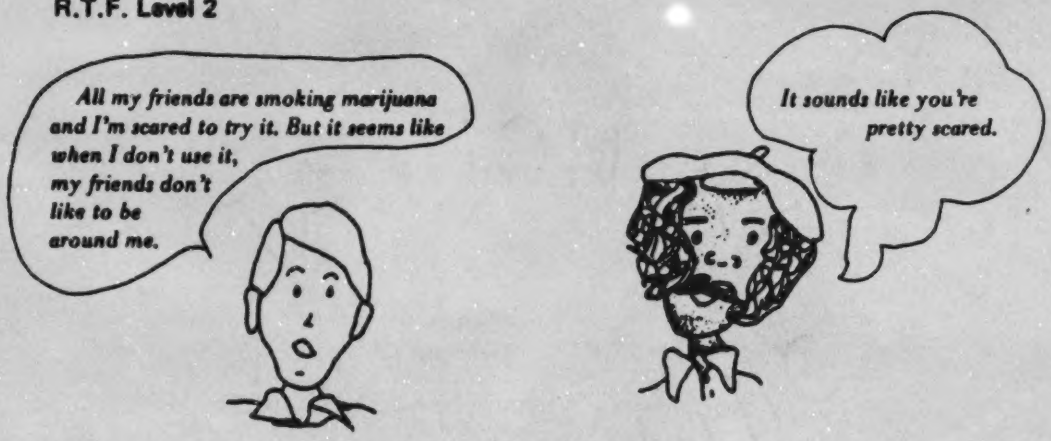
The examples below should help you learn how to rate the different levels in the Responding-to-Feelings Scale.

R.T.F. Level 1

All my friends are smoking marijuana and I'm scared to try it. But it seems like when I don't use it, my friends don't like to be around me.
Well, ya know, it's not a dangerous drug. Why don't you use it?

This listener is responding at a Level One. He has not recognized any feelings the speaker stated, but instead, he has responded to the situation. He also gave the speaker advice as a quick solution. Most likely, the speaker would be turned off.

R.T.F. Level 2


All my friends are smoking marijuana and I'm scared to try it. But it seems like when I don't use it, my friends don't like to be around me.
It sounds like you're pretty scared.

This listener is responding at a Level Two. He has *reflected* (remember the mirror) the stated feeling of the speaker (scared) and done so in a nonjudgmental way. (Note: The opposite of nonjudgmental is judgmental. An example of a judgmental response is: "You're pretty dumb to be that scared." This is *not* a helpful response; it is a punishing response.)

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R.T.F. Level 3

All my friends are smoking marijuana and I'm scared to try it. But it seems like when I don't use it, my friends don't like to be around me.
It sounds like you're scared, but I also hear you being pretty lonely now.

This listener is responding at a Level Three. He has responded to the speaker's stated feelings (scared) and labeled additional *implicit* feelings (undercurrents going on in the speaker that he hasn't labeled) in the speaker's statement (loneliness).

Taped Exercise

You are ready now to practice applying the Responding-to-Feelings Scale. Listen to the examples on the tape recorder. You will hear a speaker presenting a problem. This will be followed by three separate listener responses that you will be asked to rate according to the R.T.F. Scale. You will repeat this process twice, and then you will be asked to make your own response to some prerecorded speaker statements.

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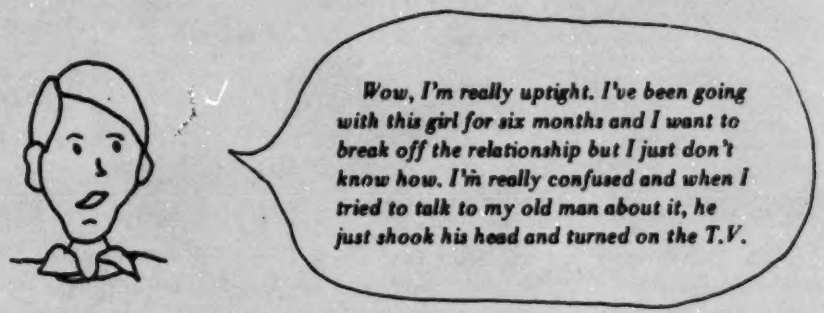
S.E.E. 4 (optional)

This is an extra practice for people who would like to reevaluate themselves on their discrimination when responding to feelings. If you don't need it, skip it.

The following presents a speaker's problem and the three responses demonstrating different levels of responding to the speaker's feelings.


Wow, I'm really uptight. I've been going with this girl for six months and I want to break off the relationship but I just don't know how. I'm really confused and when I tried to talk to my old man about it, he just shook his head and turned on the T.V.

Fill in these blanks before going on to the responses:

1. The speaker's *situation* is _____.

2. The speaker's *stated* feelings are—

   a. _____

   b. _____

3. The speaker's *implied* feelings (undercurrents) are—

   a. _____ c. _____

   b. _____ d. _____

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4. Response A:

Which of the following answers describes this response? The listener—

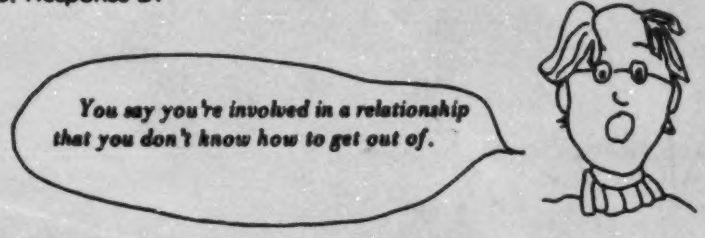
a. responds to stated feelings of the speaker, mirroring the same words with similar words;

b. denies speaker's feelings by putting speaker down, giving advice, ridiculing or coming up with quick solutions;

c. accepts the speaker's feelings (doesn't state or imply that the speaker has the *wrong* feelings or that the feelings are unimportant);

d. both a. and c.

5. Response B:



Which of these answers describes this response? The listener—

a. doesn't respond to speaker's feelings;

b. gives quick solutions;

c. responds to facts and information;

d. all of the above.

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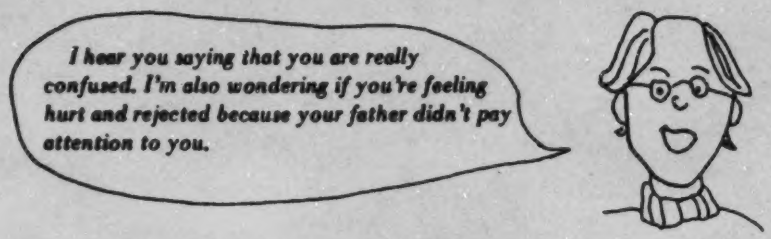
6. Response C:


I hear you saying that you are really confused. I'm also wondering if you're feeling hurt and rejected because your father didn't pay attention to you.

On what level is Response C? The listener—

a. denies speaker's feelings by coming up with a quick solution;

b. responds only to the storyline and ignores stated feelings;

c. responds to the speaker's stated feelings, and picks up some undercurrents, "hurt and rejected."

S.E.E. 4 ANSWERS

1. not knowing how to break off with his girlfriend and being ignored by his father

2. (a.) uptight
   (b.) confused

3. afraid, anxious, rejected, lonely, helpless

4. (b.) The listener comes up with a quick solution.

5. (c.) The listener responds only to the speaker's situation.

6. (c.) The listener responds to the speaker's stated feeling (confused) and picks up on undercurrent feelings of hurt and rejection.

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MODULE 8

SPECIFIC LABELING OF FEELINGS AND SOURCES

In the module entitled "Responding to Feelings," we likened a good listener to a good mirror, reflecting the speaker's feelings so that he can recognize, understand and begin to deal with them. In this module, you will learn skills to help polish that "listening mirror" well enough to give the speaker an even clearer reflection of his feelings. By focusing on the speaker's feelings that are most important to his immediate concern, using specific language, and linking the feelings to their source, your response will help the speaker sort out and clarify his feelings and identify exactly where they come from.

There are three parts to this skill: (1) responding to sources of feelings; (2) specifically labeling feelings and sources; and (3) focusing on feelings most important to the speaker; we'll take them one at a time.

Definition 12 — *Responding to sources of feelings* means responding to the concern, situation, or people that have stimulated the speaker's feelings.

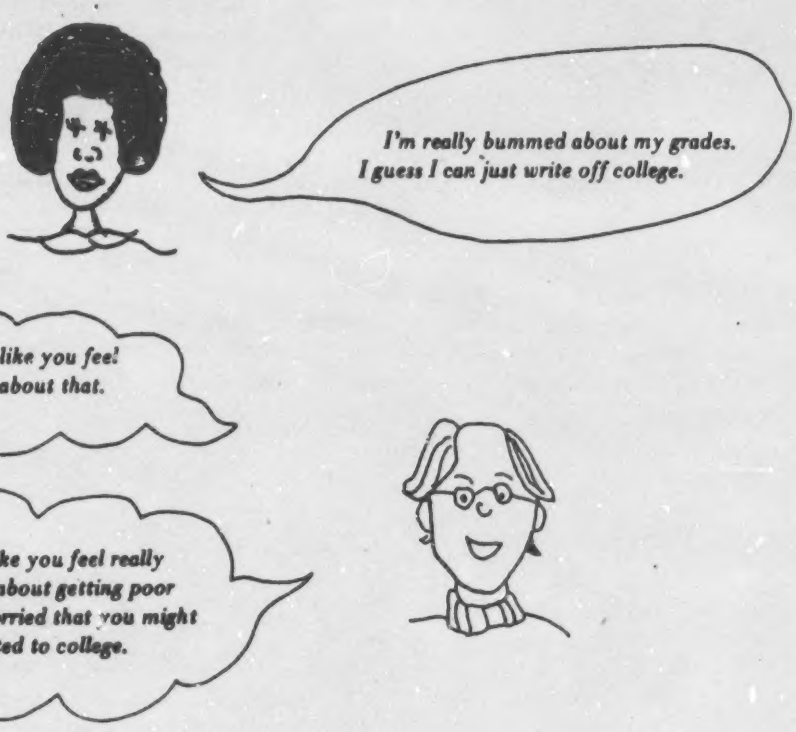
Remember that one of the gauges indicating how clearly the speaker owns his feelings is whether he identifies the source of his feelings. As a listener, your task will be to respond not only to the speaker's feelings but also to their source.

I'm really worried about my brother. He drinks every day now and he's just not himself anymore. I wish I knew how to talk to him.
It sounds like you're really worried about your brother's drinking. I'm wondering if you also feel confused about how to help him.

The listener has correctly reflected the speaker's worry about his brother's drinking so much. Notice too that the listener picked up on an undercurrent feeling ("confused") and tied it to a source ("how to help him"). Reflecting undercurrent feelings is even more helpful if you can include the source in your response.

Definition 13 *Specific labeling of feelings and sources* means responding to the speaker's feelings and sources using language that is precise, clear, and specific—not vague, abstract, and general.

This helps the listener to bring the speaker's vague descriptions into clearer focus.


I'm really bummed about my grades. I guess I can just write off college.
It sounds like you feel kind of bad about that.
It sounds like you feel really disappointed about getting poor grades and worried that you might not get accepted to college.

In his first response, the listener labeled the speaker's feeling and source with the general, vague words "bad" and "that." He even said "kind of" when the speaker owned the intensity of her feeling by saying "really."

In the second response, the listener has used specific labels (disappointed, worried) to reflect back the speaker's vague feeling ("bummed") and has used specific language to respond to the source.

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Here are some good examples of both abstract and specific words:

Vague, abstract, general	Specific
blah	frustrated
bummed out	disappointed
hassled	angry
bad	lonely
upset	worthless
good	excited

Can you think of more?

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

There is a *DO NOT* in the specific labeling. *DO NOT* say: "kind of, a little, sort of. . . ." These words minimize the feeling you are labeling, and therefore are not specific enough. (Question: Is your "kind of" the same as what another person means by "kind of. . .?" Be especially careful not to combine these words with feeling words that are not specific.

HELPFUL HINT: Some feelings can be labeled by different words that mean almost the same thing but that vary in degree (intensity). We call these related words a continuum. For instance, consider *angry* and *sad*.

ANGRY..... annoyed – irritated – disgusted – furious

SAD..... dejected – melancholy – depressed – despondent

Can you think of others?

_____ ..... _____ _____ _____ _____

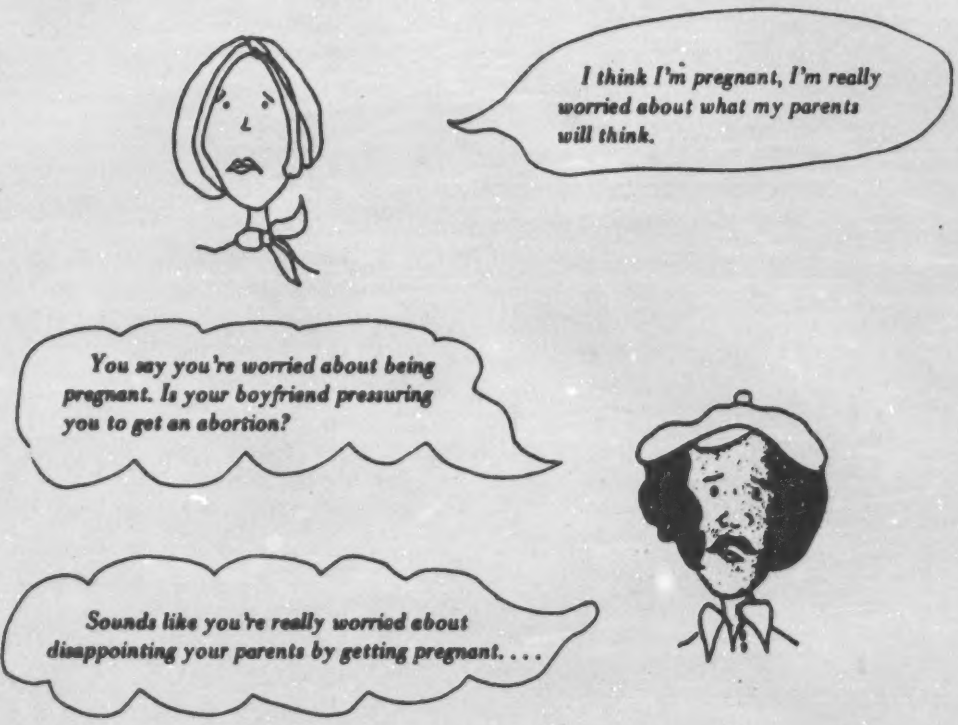
_____ ..... _____ _____ _____ _____

_____ ..... _____ _____ _____ _____

If you can learn a larger vocabulary of feeling words, most likely your specific labeling will improve.

Definition 14 *Focusing* is concentrating on those feelings and sources that are most important to the speaker's immediate (here and now) concern.

Obviously, you, as listener, won't help the speaker if you respond in a way that moves him away from his immediate concerns to other topics that have no bearing on his personal feelings. At other times, the speaker may describe several feelings and sources in the same statement. You will be very helpful to him if your response focuses on those feelings that are *most* important to his immediate concern.


I think I'm pregnant, I'm really worried about what my parents will think.
You say you're worried about being pregnant. Is your boyfriend pressuring you to get an abortion?
Sounds like you're really worried about disappointing your parents by getting pregnant. . . .

In his first response, the listener responds to the speaker's feelings, but tries to move to a topic that is irrelevant to what the speaker is saying about her parents. In the second response, the listener focuses on those feelings and sources that sound most important to the speaker's immediate concern ("worried about disappointing your parents").

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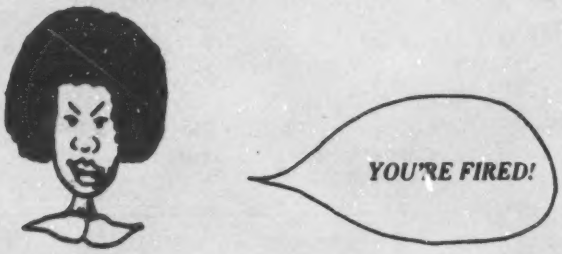
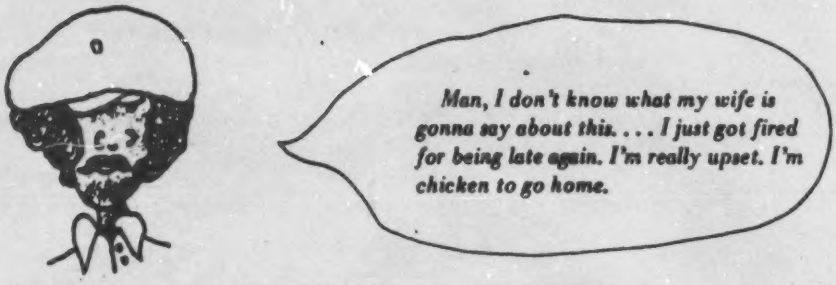
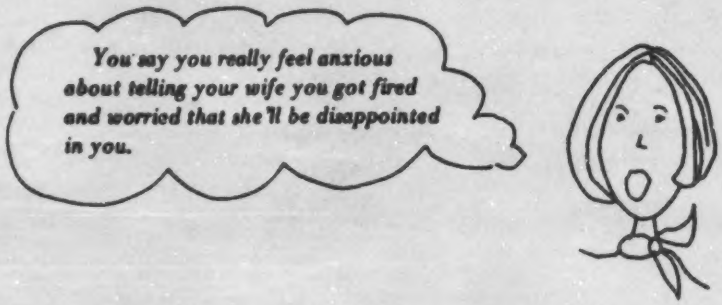
S.E.E. 5

In the listener's response, underline with one line the specific label, and with two lines the source.




Man, I don't know what my wife is gonna say about this. . . . I just got fired for being late again. I'm really upset. I'm chicken to go home.



S.E.E. 5 ANSWERS

You should have underlined "anxious" and "worried" for the specific labeling of feelings and placed two lines under "telling your wife you got fired" and "she'll be disappointed in you."

Look now at the Specific-Labeling-of-Feelings-and-Sources Scale.

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SPECIFIC-LABELING-OF-FEELINGS-AND-SOURCES SCALE

LEVEL ONE: The listener does not facilitate the speaker by—

- responding to the speaker's stated feelings but *ignoring* the *sources* of those feelings;
- *moving* the speaker away from his immediate concerns to *irrelevant*, *impersonal*, or *abstract* issues;
- responding to speaker's stated feelings and sources in language that is *less specific* than the language that the speaker used.

LEVEL TWO: The listener facilitates the speaker by—

- responding to the speaker's stated feelings but matching it to an incorrect or *inappropriate source*;
- *reflecting* the stated feelings and sources of the speaker using the same or similar words;
- *centering* on the speaker's immediate concern.

LEVEL THREE: The listener facilitates the speaker by—

- responding to the speaker's feelings and sources in language that is *more specific* than the language that the speaker used;
- *focusing* on those feelings and sources that are most important to the speaker's immediate concerns;
- responding to *stated* feelings, to *undercurrent* feelings, and to the sources of those feelings.

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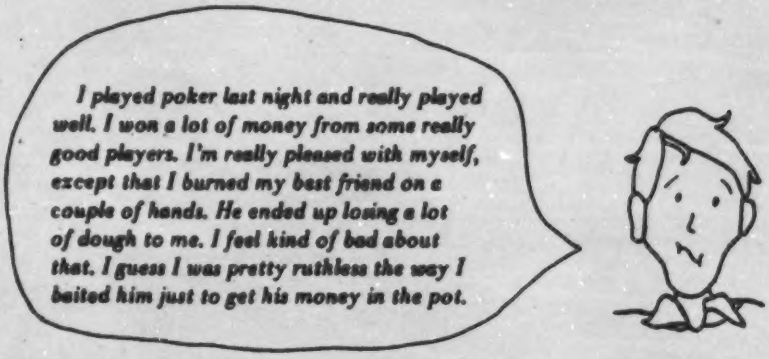
IMPORTANT REMINDER: The levels on this scale are *NOT* the same as the levels on the Responding-to-Feelings Scale. In this scale, if only the speaker's feelings are labeled, the listener is at a Level One. He must *also* label the *sources* in order to be at a Level Two. In order to be at Level Three, the listener must specifically label the feelings, match them with the appropriate sources, and respond to undercurrent feelings and sources.

Taped Exercise

Listen to the tape recorder. You will hear a speaker presenting a concern, and then three ways a listener might respond. Make sure you understand the example before you move on. After four sets of practice ratings according to the Specific-Labeling-of-Feelings-and-Sources Scale, you will be asked to write your own responses to some prerecorded speaker statements.

S.E.E. 6

If you're still confused, try this; if not, skip it.


I played poker last night and really played well. I won a lot of money from some really good players. I'm really pleased with myself, except that I burned my best friend on a couple of hands. He ended up losing a lot of dough to me. I feel kind of bad about that. I guess I was pretty ruthless the way I baited him just to get his money in the pot.

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Fill in the following before rating the responses:

1. What two feeling labels did the speaker use?

   a. _____

   b. _____

2. What are the sources for each of these feelings?

   a. _____

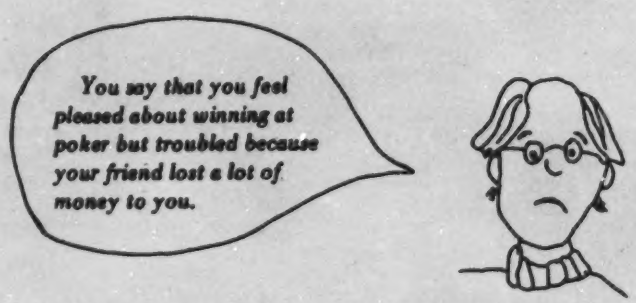
   b. _____

3. What were the feelings and sources most important to the speaker's concern?

   _____

   _____

4. Response A:



What level of responding is this? _____

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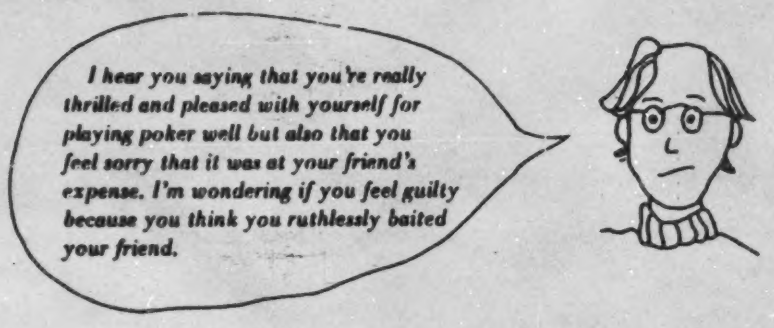
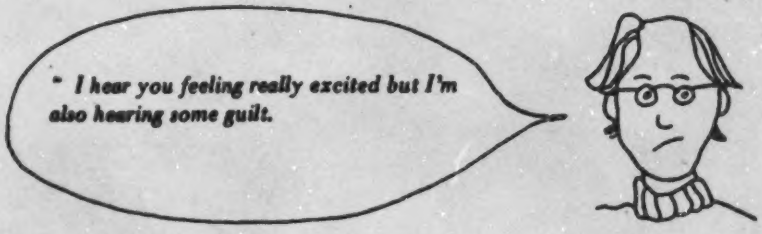
5. Response B:


I hear you saying that you're really thrilled and pleased with yourself for playing poker well but also that you feel sorry that it was at your friend's expense. I'm wondering if you feel guilty because you think you ruthlessly baited your friend.

What level of responding is this? _____

6. Response C:



What level of responding is this? _____

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S.E.E. 6 ANSWERS

1. (a.) really pleased

   (b.) kind of bad

2. (a.) playing well

   (b.) ruthlessly baiting his friend

3. feeling guilty for being ruthless

4. Level Two. The listener reflects the stated feelings and sources using words similar to those used by the speaker.

5. Level Three. The listener uses specific labeling to respond to the speaker's feelings ("thrilled," "pleased," "sorry") and sources ("playing poker well," "that it was at your friend's expense") and responds to an undercurrent feeling and source ("guilty because you ruthlessly baited your friend").

6. Level One. The listener specifically labels one of the speaker's stated feelings ("excited") and even picks up on an undercurrent ("guilt"), but does not respond to any sources of feelings.

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MODULE 9

RESPONDING TO FEELINGS IN CONFLICT

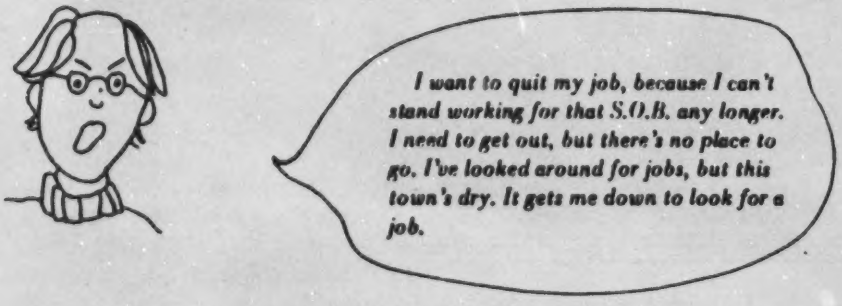
By this time, you've learned a lot of skills to help the speaker own his feelings, clarify them, and understand where they come from. The job is not complete, however, until the speaker can explore his feelings more deeply and reach an even greater understanding of the effect of his feelings on each other and his total experience.

In our definition of sources we learned that situations in which we are involved are often the source of our feelings and that sometimes one feeling can cause another feeling. This often happens when a speaker is experiencing two or more conflicting feelings at the same time and about the same thing. For example, he may be excited and enthusiastic about a new job, but also unsure of himself and worried that he won't do well. These two simultaneous feelings also serve as the source for another set of feelings: confusion or indecision about taking that new job. Sometimes this additional feeling is the one that he is most aware of. Feelings of confusion, indecision, pressure, frustration, etc. can often be overwhelming and hinder the speaker's ability to sort out all the underlying reasons for these feelings. This complicates matters for him and makes it difficult for him to make decisions or change his behavior.

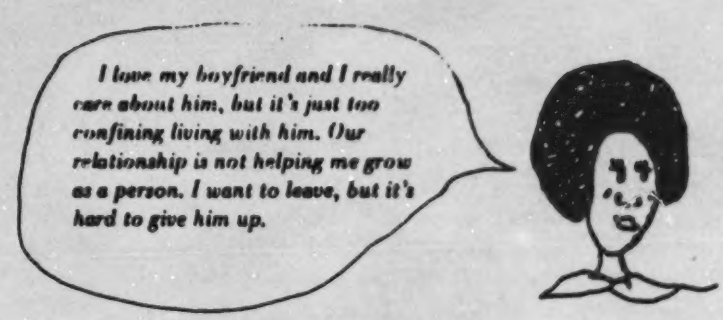
In this module, you will learn to refine your listening and responding skills in order to help the speaker deal with the problems created by his conflicting feelings.

There are three things to be aware of when dealing with a speaker who is experiencing a conflict of feelings: the situational conflict, the feelings arising from that situation, and the impact of the conflict on the speaker.

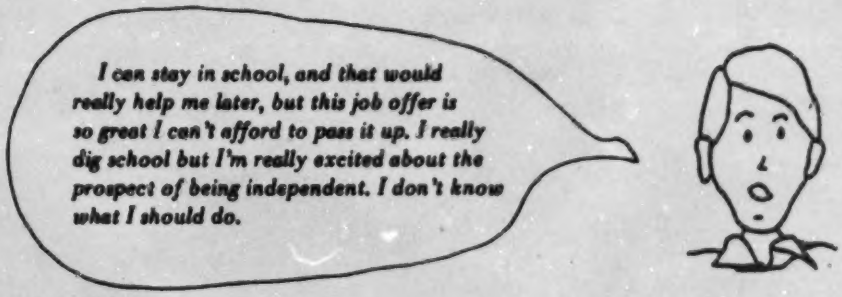
Example:


I want to quit my job, because I can't stand working for that S.O.B. any longer. I need to get out, but there's no place to go. I've looked around for jobs, but this town's dry. It gets me down to look for a job.

This speaker's *situational conflict* is that he wants to quit his job but doesn't know where to find another one.


I love my boyfriend and I really care about him, but it's just too confining living with him. Our relationship is not helping me grow as a person. I want to leave, but it's hard to give him up.

This speaker situational conflict is leaving her boyfriend or staying with him. Her *feelings in conflict* are loving and caring on the one hand but feeling confined on the other. (The sources of these feelings are loving her boyfriend and feeling confined by the relationship.)


I can stay in school, and that would really help me later, but this job offer is so great I can't afford to pass it up. I really dig school but I'm really excited about the prospect of being independent. I don't know what I should do.

This speaker's situational conflict is in choosing between staying in school or dropping out to take a job. His feelings in conflict are enthusiasm about school and excitement about taking the job. The immediate effect of this conflict is to create the additional feelings of *confusion* and being *torn*. (Note that enthusiasm and excitement are pleasant feelings when considered by themselves, but that the overall impact of both together is unpleasant.) An aid to recognizing when a speaker is experiencing feelings in conflict is the word "but." Look back at each of the examples and see if the speaker uses that word.

Let's look at another speaker and determine his situational conflict, the feelings that are in conflict, and the impact that his conflict has on his experience.

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S.E.E. 7

I really feel up against the wall. My wife's been hassling me about my friend, Norm. He's my best friend and I really enjoy hanging out with him. But whenever I spend time with him, we stay out late drinking and carousing. My wife can't stand him though and she's starting to tell me to "choose him or me." I love my wife and it really bothers me that she's upset, I mean she's everything to me, but Norm, well, he's my partner. This is a real drag!

Fill in the following blanks:

1. Situational conflict: _____ vs. _____

2. Feelings in conflict: _____ vs. _____

3. Sources of feelings in conflict:

   _____ and _____

4. Immediate impact: _____

5. Can you pick up on any undercurrent feelings and sources that might be connected to the speaker's feelings in conflict? Can you detect any additional feelings in conflict?

   _____

   _____

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S.E.E. 7 ANSWERS

1. Situational conflict: He wants to hang out with Norm but his wife tells him not to.

2. Feelings in conflict: Liking and enjoying Norm as opposed to loving but being bothered by his wife.

3. Sources of feelings in conflict: He spends time with Norm; his wife is upset.

4. Immediate impact: He feels up against the wall, pressured, unsure about what to do, torn between the two people.

5. Possible undercurrents and sources: Resentment and anger at his wife for pressuring him to choose between her and Norm; resentment toward his wife for not understanding his loyalty to Norm or his need to hang out with a good male friend; fear of damaging the relationship with either his wife or Norm; guilt over staying out late and upsetting his wife; confinement and frustration because his wife is impinging on his freedom; and worry that he's not being responsible to his marriage.

Whew! As you did this exercise you may have found that it was difficult to put the pieces of this feeling puzzle together. Imagine the confusion the speaker might be feeling in this situation. He knows that he feels "up against the wall" and that it's a "real drag." But he may not be in touch with or be able to sort out all the different feelings and the sources of those feelings that contribute to his dilemma. Study the following diagrams and see if it helps you to visualize feelings in conflict.

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Speaker feels: *up against the wall*

torn, confused, unsure, conflicted, pressured*

because

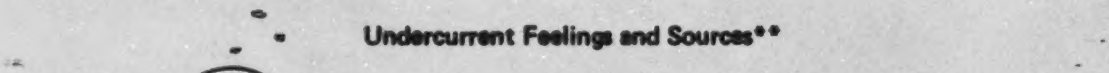
on the one hand

he likes Norm and enjoys hanging out with him

FEELINGS IN CONFLICT

on the other hand

he loves his wife and is bothered that she is upset



Undercurrent Feelings and Sources**

guilt over upsetting wife

fear of damaging either relationship

anger at wife at pressuring him to choose

resentment at wife for not understanding his loyalty

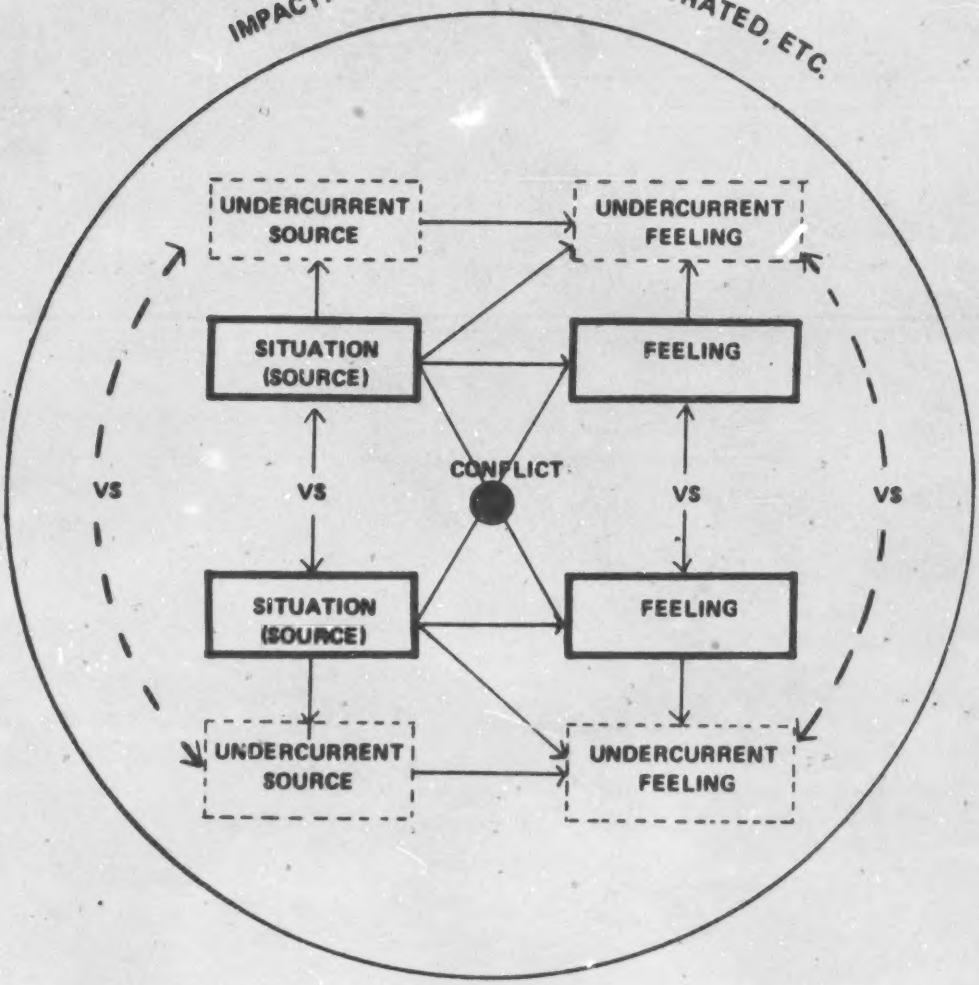
confined and stifled in marriage

worried about being irresponsible in marriage

*These are common feeling labels used to describe ways a speaker might feel the impact of his conflict. Notice they are more specific labels than "up against the wall."

**Notice how many different layers of undercurrent feelings can contribute to, complicate, or develop from the speaker's dilemma. When responding to these undercurrents, remember that they are tentative. Check them out in a way that permits the speaker to own or disallow them.

820



Thus the entire situation creates—is the source for—the feelings of being torn, confused, frustrated, etc. Conflicting feelings can arise from one situation or source, or from two or more situations or sources.

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821

Now look at the scale that describes ways to respond to the speaker's feelings in conflict. Remember that you will be most helpful to the speaker if you can make a response that helps him sort out and clarify his feelings in conflict, and understand the immediate impact of those feelings.

IMPORTANT REMINDER:

The levels on this scale are not the same as the levels on the Responding-to-Feelings and Specific-Labeling-of-Feelings-and-Sources scales. By this time you should have learned to respond to *feelings* and *sources*. In this scale however we are concerned with the more difficult task of responding to the speaker's *feelings in conflict*. If only one of the speaker's feelings and sources are labeled, the listener is at a Level One. He must at least respond to the speaker's feelings in conflict in order to be at a Level Two or above. .

822

RESPONDING-TO-FEELINGS-IN-CONFLICT SCALE

LEVEL ONE: The listener does not facilitate the speaker by—

- acknowledging the speaker's feelings in conflict but *judging* one feeling to be more right or wrong than the other, taking sides, or giving advice;
- responding to *only one* of the speaker's feelings in conflict;
- recognizing the speaker's conflict but responding only to his *situational* conflict or generalizing to examples outside the speaker's personal world.

LEVEL TWO: The listener facilitates the speaker by—

- responding to the speaker's *feelings* in conflict but not to the source(s) of those feelings;
- *reflecting* the speaker's feelings and source(s) in conflict, using the same or similar words;
- *responding* to the speaker's feelings in conflict and their source(s) by using examples the speaker has described.

LEVEL THREE: The listener facilitates the speaker by—

- responding to the speaker's stated feelings in conflict and to the source(s) of those feelings using language that is *more specific* than the language used by the speaker;
- responding to the *impact* of the speaker's conflict;
- responding to *undercurrent feelings* and *source(s)* that the speaker implies but does not clearly state.

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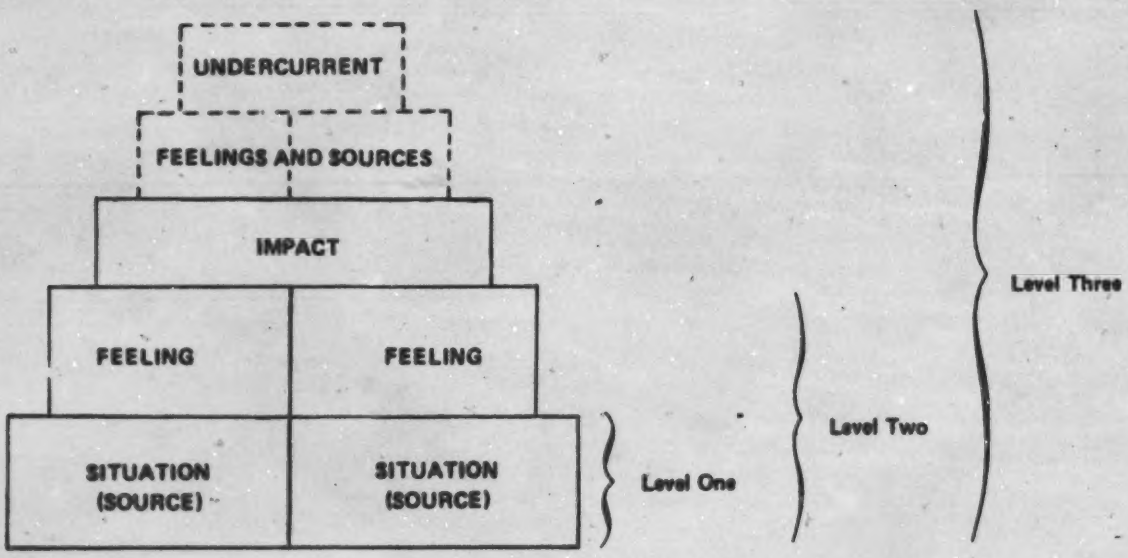
Another diagram may be helpful:



Level One: respond to situational conflict

Level Two: respond to situational conflict (source) and feelings in conflict

Level Three: respond to situational conflict, feelings in conflict, and impact of conflict *and* possibly check out undercurrents

Taped Exercise

Listen to the tape recorder again and rate listener responses according to the Responding-to-Feelings-in-Conflict Scale.

824

S.E.E. 8

Extra Practice: If you don't need it, skip it!

This scene is driving me crazy. It seems like the thing to do these days is to go to somebody's house, get drunk, do cocaine and then space out. We don't even seem to talk to each other. My friends love it and so does my husband. But we don't really have the money it takes to support that kind of play, and we'd sure be out of it if we ever got busted. What am I going to do? I don't even like what it's doing to me or my husband. He's losing weight and acting really strange and irritable more and more. It's like we're possessed. I'm afraid to say I want to stop going. My husband would hit the ceiling—or maybe he wouldn't, and I would just find myself sitting home alone.

1. Response A:

I can see you're in a bind, but I think you're really smart to consider the consequences of your actions. Many people struggle with the same problem: they like the high at first, then they start to worry about how dangerous cocaine can be.

What level of responding is this? _____

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2. Response B:

It sounds like you really feel trapped. You're disappointed about the way you, your husband and your friends interact when you do coke and even scared about the consequences, but you feel afraid and uncertain about how to tell your husband. I also hear you feeling really vulnerable right now in your relationship with him.

What level of responding is this? _____

3. Response C:

On the one hand you're hassled by this scene but on the other hand you're afraid to do anything about it.

What level of responding is this? _____

826

S.E.E. 8 ANSWERS

1. Level One. The listener recognizes a conflict but doesn't respond to the feelings in conflict. He also judges by taking sides and agreeing with her, and generalizes to experiences outside the speaker's personal world ("Many people. . . .").

2. Level Three. The listener responds to the stated feelings and sources in conflict using more specific labels, responds to the impact the feelings in conflict have on the speaker, and checks out undercurrent feelings and sources that the speaker implies.

3. Level Two. The listener responds to the speaker's feelings and sources in conflict using the same or similar words.

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MODULE 10

OWNING OF LISTENER FEELINGS

In all the skill building we have done so far we have been concentrating on your helping role as a listener. You have learned to focus on the speaker and what he is saying about his world—his feelings, sources of feelings, and feelings in conflict—in order to facilitate the speaker's clarification process. Now, we are going to focus on *your* feelings as a listener. Often, we overlook the fact that the listener also has feelings that enter into the helping relationship. Just as your responses have an impact on the speaker, what the speaker says sometimes has an effect on you.

RECOGNIZING LISTENER FEELINGS

You have probably experienced some different kinds of feelings as you have listened to the speakers so far. For example, did you ever "tune out" a speaker, find yourself not liking a speaker, or want to make the speaker feel better instead of reflecting his painful feelings? Each of those experiences could stem from feelings that were stimulated in you by something the speaker said.

The first step in owning listener feelings is to be able to recognize your feelings and understand where they come from. If this sounds familiar, you may recall the Owning-of-Feelings Scale, in which you learned to listen to a speaker owning his feelings. This process can give you added insight about the experience a speaker has when he is presenting a problem to you.

Taped Exercise

As practice in OLF we're going to ask you to close your eyes and pretend that the person on the tape recorder is talking directly to you. Try to get in touch with any feelings you may be experiencing and determine where they're coming from. After the tape recorded statement we will ask you to OLF (it might be helpful to review the Owning-of-Feeling Scale) and share your feelings with the group. Only by openly expressing your feelings and honestly exploring them will you get a good idea of how well you can own your feelings.

828

Remember that you don't have to feel a certain way. Each person may have different feelings stimulated by the same speaker. Also, right now you don't have to *do* anything with your feelings except own them. The following questions may help you in OLF.

What is the speaker saying?

What impact is the speaker having on me?

What am I thinking?

What am I feeling?

What kind of feeling labels can I put on those emotions?

What are the sources of those feelings?

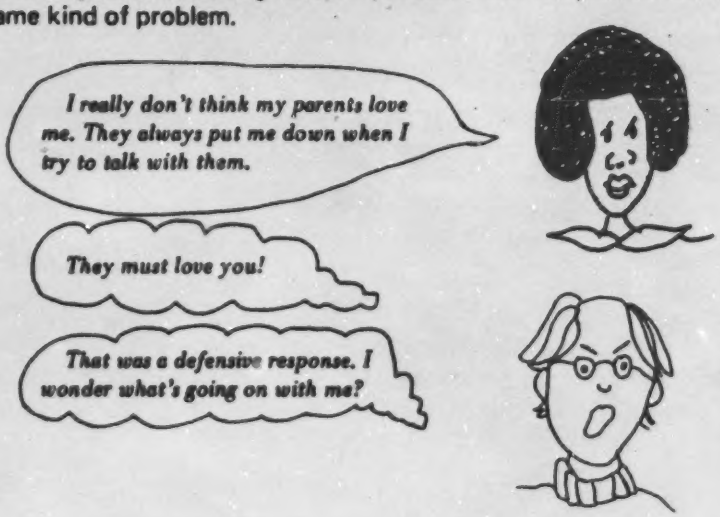
Have I ever felt that way before?

Do I want to say anything to the speaker?

LISTENER ROADBLOCKS

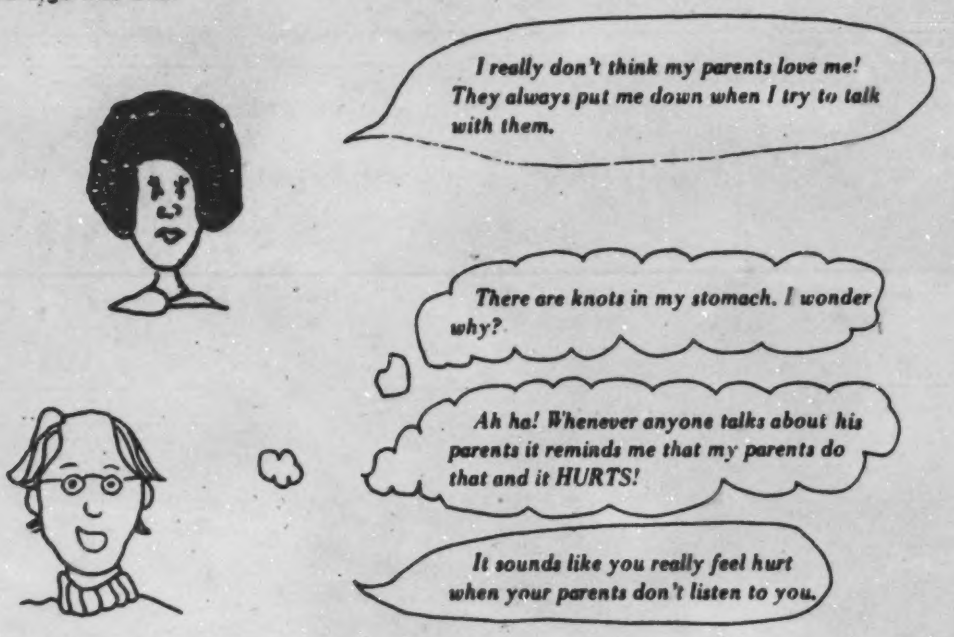
Now that you have had some practice in the first part of OLF—recognizing feelings and understanding where they come from—you're ready for the next step. When what a speaker is saying has an impact on you as a listener, it is sometimes difficult to keep listening, hear the speaker accurately, or respond effectively. We call this a listener *roadblock*.

Suppose a speaker is talking about a problem with his parents and you as a listener have the same kind of problem.


I really don't think my parents love me. They always put me down when I try to talk with them.
They must love you!
That was a defensive response. I wonder what's going on with me?

Do you think a listener roadblock caused this Level One defensive response?

By being able to recognize your feelings as a listener and the roadblocks they create, the response could go like this:


I really don't think my parents love me! They always put me down when I try to talk with them.
There are knots in my stomach. I wonder why?
Ah ha! Whenever anyone talks about his parents it reminds me that my parents do that and it HURTS!
It sounds like you really feel hurt when your parents don't listen to you.

Can you tell the difference? In the listener's first response, he wasn't able to get in touch with his feelings and become aware of his listener roadblock before he responded. In the second case, he was able to recognize his feelings (hurt and defensive), see the roadblock they created, and move around it. He listened to the rumbling in his stomach and then was able to respond to the *speaker's* feelings instead of his own.

S.E.E. 9

1. Sometimes as a listener your own feelings get in the way of hearing what is going on in a speaker. Put the following steps in the order that best describes how you as a listener can tune into what's happening to *you*, so that you can recognize your feelings and see where they come from.

   A. What are the sources of my feelings?

   B. What is the speaker saying to me?

   C. What impact is the speaker having on my emotions?

   D. What are the feeling labels that I am putting on those emotions?

   E. What do I want to say to the speaker?

2. Why is it good for me as a listener to be in touch with my own feelings? Is it so that I can–

   A. have an idea of the process that a speaker goes through when presenting a problem?

   B. take the focus off the speaker's problem and get into my own problem?

   C. keep my own problem from turning into a roadblock for the speaker?

   D. Both A and C.

S.E.E. 9 ANSWERS

1. The correct order is B, C, D, A, E.

   What is the speaker saying to me?

   What is the impact the speaker is having on my emotions?

   What are the feeling labels that I put on those undercurrents?

   What are the sources of my feelings?

   What do I want to say to the speaker?

2. Both A and C are correct. A good listener understands the process of owning of feelings and knows how to identify his own feelings so that they don't get in the way of listening to the speaker.

ROADBLOCK MOVERS

The most difficult skill involved in Owning of Listener Feelings, after recognizing your feelings and the roadblock they create for you as a listener, is moving around the listener roadblocks whenever they occur. Sometimes you will decide to share your listener feelings with the speaker. At other times you may recognize your feelings but choose not to share them with the speaker. The criterion you should use is the extent to which your expressing your feelings will enhance or retard the helping relationship. To do this you will have to assess the effect of the roadblock created by your listener feelings.

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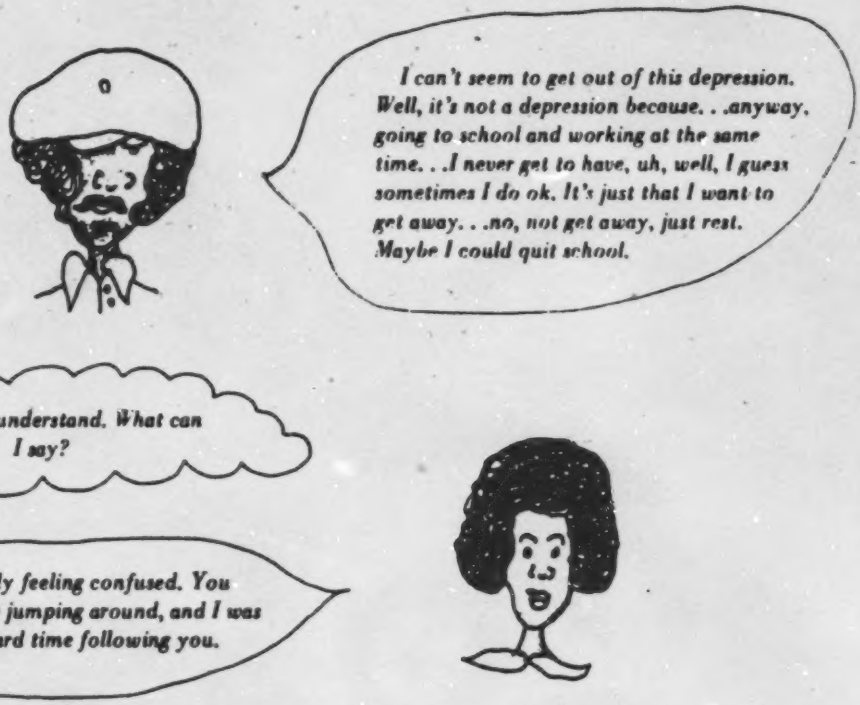
When the listener in our second example recognized his feelings he was able to set aside the listener roadblock and respond effectively to what the speaker was saying about her feelings, *without* expressing his feelings to her. Sometimes, however, a listener roadblock will have a significant enough effect on the listener's ability to continue that he will have to employ a "roadblock mover response."

Definition 15 A *roadblock mover response* is a response in which a listener moves roadblocks by (verbally) owning his feelings, without taking the focus from the speaker's immediate concern.

Let's look at some situations when it might be helpful to share your feelings with the speaker.

Examples:

Roadblock Mover 1: The listener owns feelings of confusion and asks for clarification about what the speaker has said.


I can't seem to get out of this depression. Well, it's not a depression because. . .anyway, going to school and working at the same time. . .I never get to have, uh, well, I guess sometimes I do ok. It's just that I want to get away. . .no, not get away, just rest. Maybe I could quit school.
I don't understand. What can I say?
I'm really feeling confused. You seem to be jumping around, and I was having a hard time following you.

The roadblock that needs to be removed is the listener's feeling confused.

Roadblock Mover 2: The listener owns his feelings of being pressured, rejected, seduced, threatened, intimidated, or attracted to the speaker. This describes the speaker's affect on the listener and how the resulting listener feelings get in the way of working on the speaker's problem.

I want you to give me some answers right now! That's why I came here.

I feel like i'm getting a lot of pressure to solve the speaker's problem.

I'm feeling a lot of pressure from you to find some quick answers. I want to check that out with you because it seems to be getting in the way of your working on your problem.

Roadblock Mover 3: The listener owns feelings created by identification with the speaker's concern. This clears the air and keeps the listener from focusing on his own feelings or problems.

I just don't know what to do. My daughter–she's only sixteen–has a drinking problem. I don't know whether I should keep punishing her or try to understand her more. It just breaks my heart when she comes home drunk.
Wow! That's happening with my sister. I don't know what to do either.
That puts me in touch with a lot of pain. I have that problem with my sister. I can really hear you feeling heartbroken over your daughter's problem and confused about how to help.

Roadblock Mover 4: The listener owns feelings that are a result of the speaker's impact on her in order to help the speaker gain additional insight into her immediate concern.

(Caution: The listener must use good judgment in this case. She must have enough data from her interaction with the speaker to know that her perception is valid and helpful. She should also avoid deep, analytical approaches.)

Let's look at a very short one-act play.

(Assume the listener knows a lot about the speaker including the fact that she has been a call girl and that she tends to dress in what could be regarded as a seductive fashion.)

Speaker: *I'm having a lot of trouble on my job. The men I work with keep coming on to me and it really makes me uptight.*

Listener: *I hear you saying that you're distressed by the way your male coworkers relate to you.*

Speaker: *Yeah. I don't feel like they have any respect for me. I want this job to turn out for me but I feel threatened and insecure because I'm afraid my boss—she's a woman—is going to fire me because all the men keep flirting with me.*

Listener: *You say you're afraid that you'll be fired because the men flirt with you. I wonder if you feel helpless to change that situation.*

Speaker: *Yeah. I don't know how I can ice all that funny stuff and still keep a good working relationship going.*

Listener: *You know, I feel very attracted to you myself sometimes because of the way you dress and relate to me. I wonder if you can see any connection to your situation at work.*

By sharing his feelings about the speaker, the listener gives her additional data to understand her situation more clearly.

S.E.E. 10

1. Which of the following are good reasons to OLF?

   A. The speaker is having an impact on you as a listener that prevents the relationship from focusing on the speaker's problem.

   B. You, the listener, think that the speaker is behaving toward you in the same way that he behaves toward others.

   C. You as a listener are confused and need more information in order to understand.

   D. All of the above.

2. Which one of the following answers is an *inappropriate* way for a listener to seek clarification from a speaker?

   A. *I'm feeling pretty confused and I guess I'd like you to help me out by slowing down a bit.*

   B. *I feel lost right now. I guess you could help me by talking about that last part again.*

   C. *You are really being confusing.*

3. Which of the following statements might the *listener* make in order to help a speaker focus on what's happening "here and now" between the speaker and the listener?

   A. *I'm getting frustrated because I keep thinking that this is not what you want to talk about.*

   B. *I keep feeling a lot of irritation, and it seems those feelings are coming from your wanting to label me as a "head shrinker." I would like to get that straightened out before we go on.*

   C. *I feel you shutting me out and that is making me withdraw. I think that it would be helpful if we dealt with that before we go on.*

   D. All of the above.

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S.E.E. 10 ANSWERS

1. (D.) If you missed this, review the description and the examples of roadblocks.

2. (C.) The statement by the listener to the speaker, "you are really being confusing," dumps the responsibility for the confusion on the speaker and is judgmental. Not only did the speaker come in with a problem, he now has a new one: namely, he's not even competent to talk about his problem! This response is also an example of a listener's denying his own feelings of confusion by blaming the confusion on someone else. (Check the Level One section of the Owning-of-Feelings Scale p. II-6-2.)

3. (D.) All three responses are a way to work on an immediate roadblock between the speaker and the listener.

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MODULE 11

IPR: INTERPERSONAL PROCESS RECALL

You have now completed all the prerecorded experiences and learned to make your own initial responses according to the scales. You have also learned to recognize your own feelings; you know that they can either present roadblocks to your responses to the speaker, or offer the speaker valuable insights into the effects of his behavior on others. Your task now will be to *combine* all the skills you have learned and *practice* them in a three to eight minute interaction (speaker-listener communication process) with a fellow group member.

Definition 16

Interpersonal Process (IP) is an interaction between two members of the group. One person, the speaker, presents a *real* concern to the other person, the listener, who tries to use the skills learned so far to listen and respond empathically. A tape recorder is used to record this interaction.

Definition 17

Recall is a process that takes place after the initial interaction. During recall the speaker and listener are joined by a third party, the *recaller*, with whom they review the interpersonal process. (This is why the interaction was recorded.) The purpose of the recall is to give the listener the opportunity to explore his listening behavior. The listener hears again what the speaker is saying and how he is responding to the speaker. With the assistance of the recaller as a guide during this exploration, the listener can recall the thoughts and feelings he was experiencing during the interaction. With the assistance of the speaker, the listener can find out if he was "in tune" with what the speaker was saying about his personal world.

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NOTE: The tape recorder is a helpful tool in the recall process. The recorded interaction, however, will be erased after the recall so that what occurred during the IPR can be kept *confidential* within the small group. Do not reveal the concerns that people presented in your small group to anyone outside of the small group.

The IPR is a task that involves three people working at one time. Everyone in the group will have the opportunity to be a speaker and, more importantly, a listener. The trainer will be the recaller during the first few IPRs. As members of the group learn this technique, they too will have the opportunity to participate as recallers.

If you are not one of the three people working during the IPR, silently observe both the interaction and recall. After the recall is concluded, you will be called upon to give feedback to the listener about his listening behavior. Remember the "Guidelines for Feedback" so that your feedback will help the listener improve his listening skills. You might also want to take advantage of your position as "armchair listener" to recognize points you want to remember for yourself when it is your turn to listen.

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INTERACTION

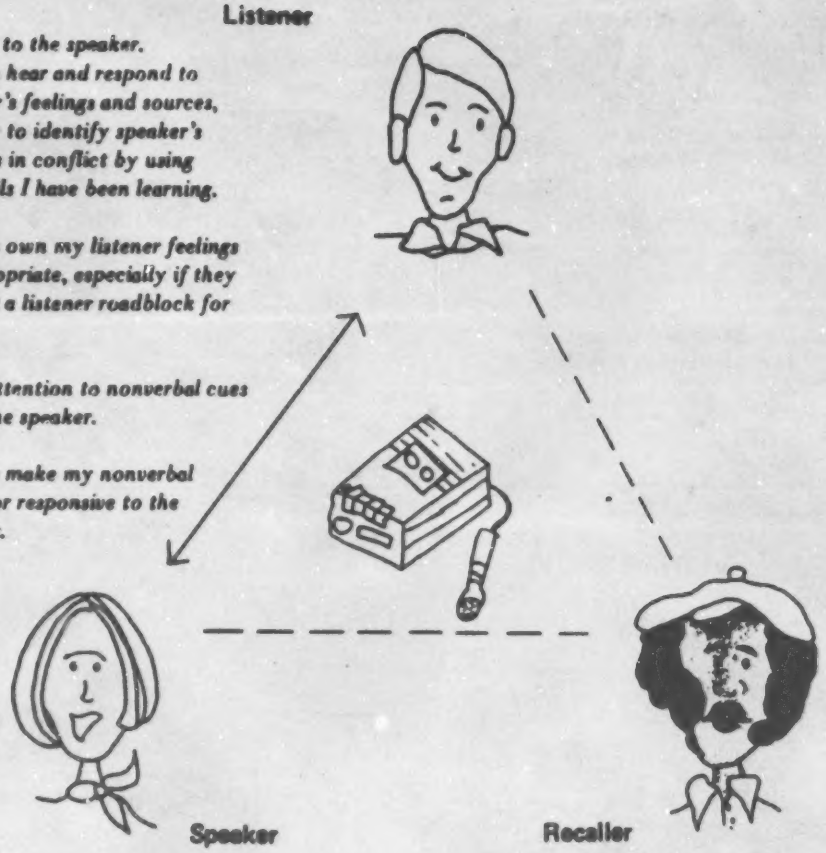
Listener

I listen to the speaker. I try to hear and respond to speaker's feelings and sources, and try to identify speaker's feelings in conflict by using the skills I have been learning.

I try to own my listener feelings if appropriate, especially if they present a listener roadblock for me.

I pay attention to nonverbal cues from the speaker.

I try to make my nonverbal behavior responsive to the speaker.



Speaker

I present a recent, real concern that has real feelings connected to it.

I try to present a concern that I feel comfortable talking about, and that I can stop talking about after the interaction.

I try to own my feelings.

Recaller

I remain silent and unobtrusive.

I listen to the interaction carefully and objectively.

I watch for listener and speaker nonverbal behavior.

Group: *We listen to and watch the interaction, trying to hear what the speaker is saying about her feelings and how the listener is responding. We silently formulate our feedback to the listener and save it for the feedback portion of the IPR.*

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RECALL

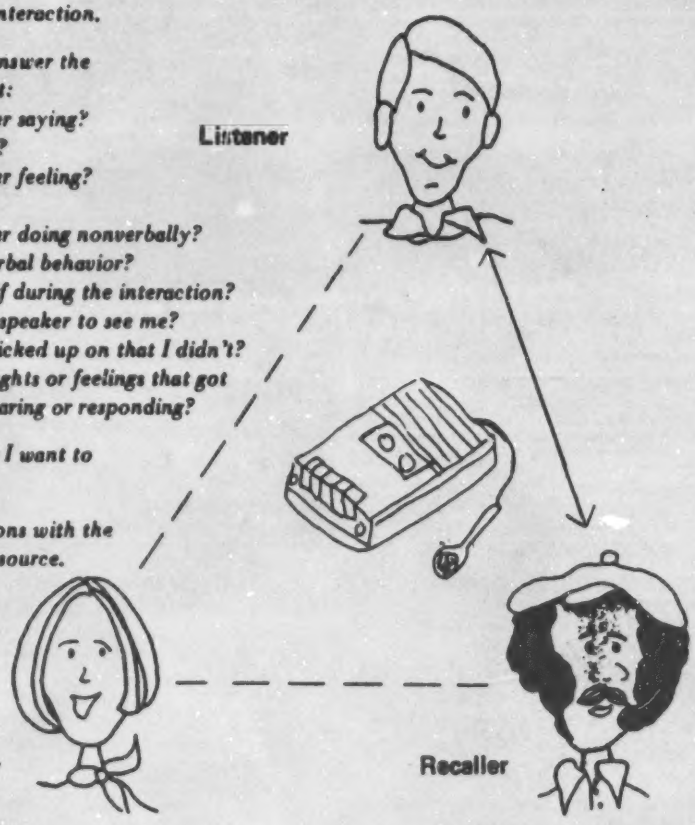
I listen to the recorded interaction.

I ask myself and try to answer the recaller's questions about:

- *What was the speaker saying?*
- *What was I thinking?*
- *What was the speaker feeling?*
- *What was I feeling?*
- *What was the speaker doing nonverbally?*
- *What was my nonverbal behavior?*
- *How did I see myself during the interaction?*
- *How did I want the speaker to see me?*
- *What could I have picked up on that I didn't?*
- *Were there any thoughts or feelings that got in the way of my hearing or responding?*

I stop the tape whenever I want to explore these questions.

I talk about these questions with the speaker, using her as a resource.



I remain silent and listen to the recorded interaction.

I serve as a resource to the listener as he tries to make discoveries about his thoughts and feelings during the interaction.

I answer the listener's questions about–

- *how I felt about him as a listener;*
- *how his responses clarified or confused my thoughts and feelings during the interaction.*

I focus on the taped interaction and on the listener.

I assist the listener as he explores his thoughts and feelings during the interaction.

I draw in the speaker as a resource for the listener's self-discoveries.

I remain patient, interested, and neutral.

I initiate listener self-exploration by asking the listener open-ended questions.

I follow the listener's lead instead of my own agenda.

Group: *We silently listen to the recall paying particular attention to the recaller and his recall behavior.*

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FEEDBACK

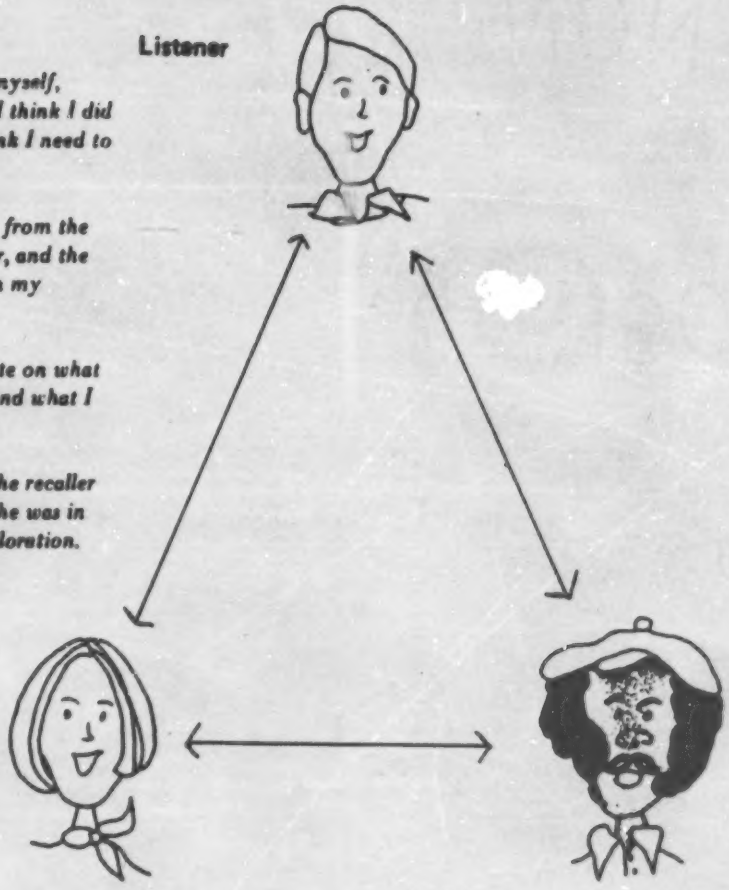
Listener

I give feedback to myself, summarizing what I think I did well and what I think I need to improve.

I listen to feedback from the recaller, the speaker, and the rest of the group on my listening behavior.

I make a mental note on what I need to improve and what I do well.

I give feedback to the recaller on how facilitative he was in helping my self-exploration.



Speaker

I give feedback to the listener about his responses to my feelings and his nonverbal behavior.

Recaller

I give feedback to the listener about his listening behavior during the interaction and his self-exploration during the recall.

Group: *We give feedback to the listener and recaller, using the guidelines for feedback. (Don't neglect giving positive feedback for a job well done.)*

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LISTENER'S PERSONAL CHECKLIST

Things I need to work on:

Example: *I have a hard time responding to certain feelings (give examples).*
I am judgmental (give examples).
I ask too many questions (give examples).

Things I do well:

Example: *My nonverbal eye contact is good.*
I do well with conflicts.

Questions I have:

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UNIT III

ATTITUDES AND VALUES

INTRODUCTION

The focus of the preceding unit, *Empathy*, was on the first phase of the helping relationship, in which the listener facilitates the speaker's exploration and clarification of his feelings. The second phase of the helping process explores another set of dynamic forces—the speaker's values—and the dimension they add to the speaker's world. By helping the speaker to examine his perceptions of the world around him and to integrate those perceptions into his life, you give him a better understanding of the way in which his feelings, thinking, and behavior fit together. Thus, the foundation for *Problem Solving* is laid: the speaker has enough information about the forces at work in a given situation to decide upon a course of action to solve his problem.

For instance, if a speaker says, "I'm really worried about not getting accepted to medical school," the feelings and sources seem clear. Beyond that surface level source, however, something else may be at work. What does medical school represent to the speaker? Could the speaker's values make "not getting accepted to medical school" a source of anxiety?

Consider the speaker who says that she believes in legalized abortion and freedom of choice: she thinks that raising a child at this point in her life would interfere with her goal of becoming a junior member in a law firm, but feels indecision, fear, confusion, and guilt about aborting her pregnancy. What could her feelings indicate?

Before you are able to understand what a speaker is saying about his values, whether his values are involved in a given situation, and whether he recognizes their effect on him, it is important to learn what it sounds like when a speaker is expressing values. Before we do this, we will first focus on another type of motivation—attitudes—and how they are related to, but different from, values.

There are three modules in Unit III:

- Module 12: Attitudes
- Module 13: Values
- Module 14: Interpersonal Process Recall (Part II)

This unit will require about 6 hours to complete.

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MODULE 12

ATTITUDES

Attitudes are sometimes confused with values. Attitudes may give you clues to a person's values, but are essentially different in terms of the impact they have on a speaker's world. Both attitudes and values influence the way in which a speaker relates to his environment: attitudes affect his thinking about or understanding of things; values more directly affect his behavior.

Definition 18 *Attitudes* are a collection of broad beliefs or opinions organized around a particular subject or topic that have been gained through experience.

CHARACTERISTICS OF ATTITUDES

1. *Attitudes are shaped by our experience.* Our experiences include parent teaching, peer group pressures, media exposure, history lessons, personal relationships, etc. These learning experiences often take place subconsciously and are sometimes accepted without question as part of our culture. We learn such things as:
   - Taxation without representation is wrong.
   - Perspiration stains are unattractive.
   - Long hair on men is sexy, or long hair on men is effeminate.
   - Women are poor drivers.
   - Communism is evil.

   Hence, attitudes are directional in that we make decisions based on what we personally believe: for example, we decide to become a Republican, a Democrat, or a third-party advocate based on our particular political attitudes.

2. *Attitudes are indicated by the words we use to describe our experience.* Words describe our experiences and our reactions to them. "Tapes" that go around in our minds say things like:
   - A *good* husband *should* be considerate.
   - A *responsible* adult *shouldn't* be collecting welfare.
   - It's *always better* to turn the other cheek.
   - Sex before marriage is *wrong*.
   - Geometry is *boring*.
   - Men should *never* cry.
   - The *right* thing to do when you see a mugging is to keep walking.

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The words people use indicate their attitudes. Look at two possible attitudes toward sex.

A positive attitude	A negative attitude
fulfilling	*necessary*
fun	*boring*
exciting	*scary*
fantastic	*disgusting*

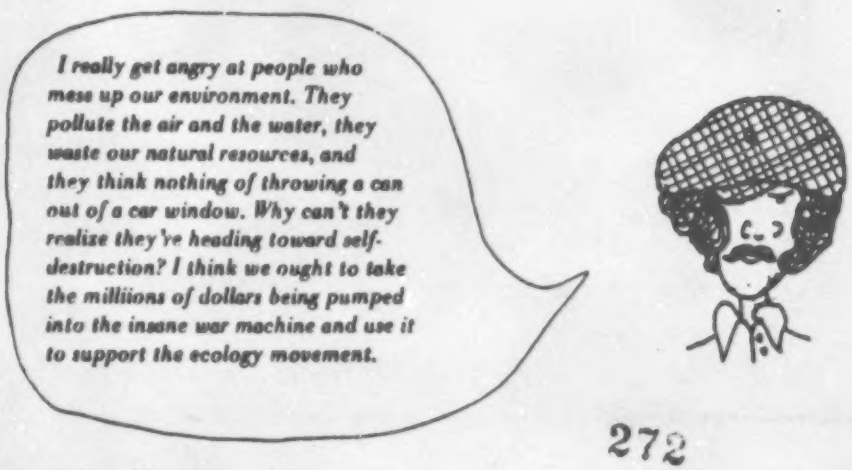
When words such as "right" and "wrong" or "should" and "should not" are attached to the opinions that make up attitudes, these attitudes become judgments—of *ourselves* as well as others.

3. *Attitudes influence our sense of role and our expectations.* They affect our thinking about other people's behavior and the way we experience our world. They can also affect how we *think* we should act in certain situations. Let's assume you have heard about a particular job opening. Perhaps experience has taught you that applying for a job is a hassle: you know that there is a certain way to dress and to carry yourself during the interview, but you find it demeaning because you probably will get rejected anyway. At the same time, you really want the job because you believe that at your age you should already have a career, and that getting this job will start you on the road to success. The words you might use to describe your feelings in this situation are *apprehensive*, *anxious*, and *discouraged* because of your negative attitude toward job interviews. However, you will probably put on that tie or pants suit and go through the interview because of a stronger motivation—the value of having that job.

RECOGNIZING ATTITUDES

Now, let's practice recognizing attitudes in a speaker's statement. Remember that attitudes are *broad opinions* or *beliefs* focused on a subject or topic.

S.E.E. 11


I really get angry at people who mess up our environment. They pollute the air and the water, they waste our natural resources, and they think nothing of throwing a can out of a car window. Why can't they realize they're heading toward self-destruction? I think we ought to take the milliions of dollars being pumped into the insane war machine and use it to support the ecology movement.

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Fill in the blanks for the following questions.

1. What was the topic around which the speaker's attitude centered?

   _____

   There was also a hint about another topic. What was it?

   _____

2. Were the attitudes positive or negative? (Use a plus or a minus sign.)

   First attitude _____

   Hinted attitude _____

3. Were there any feelings attached to the attitude? If so, label both the *stated* and the *implied* feelings.

   _____ _____ _____

   _____ _____ _____

S.E.E. 11 ANSWERS

1. Ecology (cleaning up the environment) was the stated topic.
   War was the hinted topic.

2. The attitude toward ecology is positive. (Key clue word: *supporting*. Key clue feeling: *angry* at people who mess up the environment.)
   The attitude toward war is negative. (Key clue word: *insane*.)

3. Stated feeling: angry
   Implied feelings: urgency, frustration
   (You may have thought of more. Discuss them with your group.)

Taped Exercise, Part 1

Listen to the Values and Attitudes Exploration Tape (Section One). You will hear a speaker's statement that reflects an *attitude*. Listen for the topic. Then decide if the speaker is expressing a positive or negative attitude (remember to listen for clue words and feelings). Check yourself by discussing your observations with your group.

Taped Exercise, Part 2

Listen to the tape recorder again. You will hear a speaker discussing personal attitudes. Your task now is simply to share with the group your attitude on the *same topic* and discuss how you came to have those beliefs and opinions.

ATTITUDES AS ROADBLOCKS

There's another important reason to be aware of attitudes. In owning of listener feelings, you examined the ways in which your feelings as a listener can sometimes get in the way of hearing and responding effectively to what a speaker is saying. In a similar way, your attitudes can also interfere with maintaining your role in the helping relationship. To what extent do your attitudes about certain kinds of people affect you as a helper? Consider, for example, the following situation:

> A black girl feels torn because she is pregnant with her white boyfriend's baby and plans to have an abortion because she doesn't feel responsible enough at this point in her life to raise a child; at the same time she feels anxious because she wants to be able to talk to her parents about it but doesn't know how. If you as a listener have a negative attitude toward abortion, interracial marriage, or premarital sex, and allow these attitudes to get in the way, how empathic do you think your response to the speaker will be?

SUMMARY

Our purpose here has been to define attitudes. Attitudes are opinions or beliefs that influence how a person perceives and relates to someone or something. They are determined by a rational process that associates an event, a person, a place or a thing with our experiences.

Sometimes, however, another more personal and immediate force is stronger than or in conflict with the force exerted by attitudes. For example, our friends may believe that it is "cool" for us to drive over the speed limit; but if we place a greater importance on safety and responsibility than on being cool, we will act according to what we value most and drive safely. This is where *values* come in: they are discussed in Module 13.

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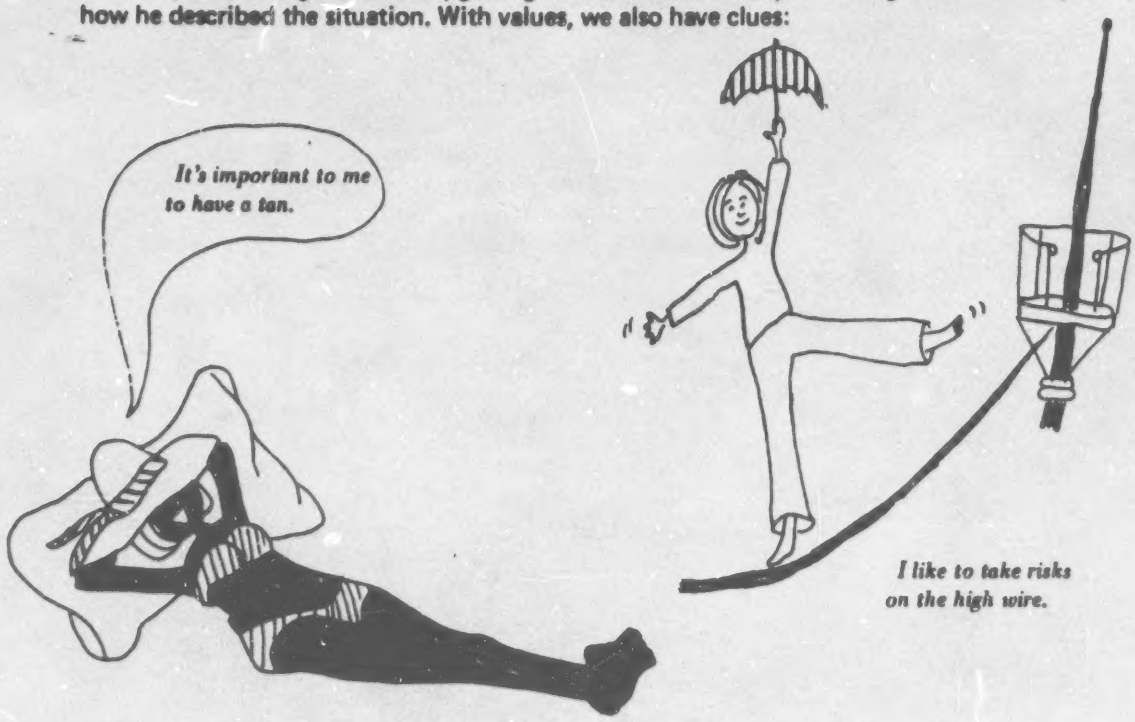
MODULE 13

VALUES

Now that we have learned about attitudes, we want to move to a more personal expression of what motivates people. Whereas attitudes are expressed in statements about the world or about other people, values are expressed in statements that are relevant to one's own life. For example, a speaker who says, "Everyone in this country has the right to the same standards of excellence in education," is saying something very different if she says, "Even though I believe in equal opportunity, I'm not going to subject my little girl to busing; her emotional well being is too important to me and I'm not going to risk that." Can you tell which statement expresses an attitude and which expresses a value?

INDICATIONS OF VALUES

How do we know when a person is expressing his values? Sometimes, the listener has to be a detective to really understand the values a person has. Just as with feelings, the speaker hasn't always clearly identified his values when they are a factor in his concern. Remember when we were trying to identify what a speaker was feeling? We looked for clues: the tone of voice, the feeling words used, getting an idea of what the speaker might feel based upon how he described the situation. With values, we also have clues:



Clue 1: Sometimes we attach *words* to experiences, words that give clues to values:

I prize. . . . I cherish. . . . It's important to me that. . . . I like that. . . .

or *I don't like that. . . . It's unimportant to me that. . . .*

or *That feels good. . . . That feels bad. . . .*

What other phrases are there that indicate values?

Clue 2: Sometimes we designate *symbols* to represent our values. We invest a lot of energy pursuing, attaining, or protecting these symbols because of their importance to us. Here are some expressions of value through symbols:

- *It's important to have a suntan.*
- *My relationship is something I prize.*
- *I like to take risks.*
- *I just have to be able to own a house of my own.*
- *If I don't get that job I don't know what I'll do.*
- *I really want to get accepted to law school.*

What other kinds of things are symbols of values?

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Clue 3: Sometimes a person's values are expressed through behavior. What one strives for and what one avoids show what one values.

A speaker's description of his behavior and activities might also suggest what his values are. Can you tell what values are expressed below?

- *I stayed up until 2:00 a.m. studying for my exam.*
- *I saved $200 for my vacation but I spent it all on dope.*
- *I'm enrolling in a natural childbirth class next week.*

What other kinds of behavior are there that give clues to values?

S.E.E. 12

I'm really worried. My director at the counseling center wants me to go to some management training next week. He says that it will give me some more skills and prepare me to become his deputy. I really want to do it—it's a great opportunity for me and I like the challenge. The only thing is that being a counselor is really important to me. I even come in on weekends to spend extra time with my caseload. I'm afraid I just don't have the time to take on more responsibilities and still do a good job.

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Fill in the blanks for the following questions.

1. What words does the speaker use to describe his values?

_____

2. What symbols does the speaker use to describe his values?

_____

3. What activities of the speaker indicate his values?

_____

4. What feelings is the speaker experiencing?

_____

5. Can you describe the speaker's values?

_____

6. Are there any other values present that the speaker hints at?

_____

S.E.E. 12 ANSWERS

1. "want to do it," "great opportunity," "really important"
2. being a counselor
3. come in on weekends, spend extra time
4. worried, afraid
5. helping people
6. doing a good job, accepting a challenge

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DEFINITION OF VALUE

Now that we have looked at ways that a speaker might talk about or describe his values, let's examine a value itself. Values do not pertain to abstract issues but rather to personally important issues.

Definition 19 — A *value* is the personal, relative worth attributed to someone or something that is expressed by words, symbols, or behavior, and that influences how we relate to people, places, things, and events in our lives.

Values give direction to our lives. We invest personal energy—mental, emotional, and physical—in the pursuit of what's important to us. In this way, our values are connected to our feelings, thoughts, behaviors, and environment. What we really value is reflected by our activities: we choose what we consider to be worthwhile; we act on those decisions by pursuing those goals; and we feel fulfilled when we seem to be reaching them.

RESPONDING TO VALUES

Now you should have enough information about values to recognize when a speaker is talking about *his* values. This is important because a person's values sometimes create problems for him and complicate his situation.

When you as a listener are able to recognize and respond to a speaker's values, you can help him sort out another factor in his concern or problem situation. Later, in Problem Solving, by being able to tie everything together in a given situation, the speaker will be better equipped to make decisions about his problem.

The next step is to look at the Responding-to-Values Scale. In this scale, it is the speaker's *values* that are of primary concern. In order to make a Level Two response, the listener must respond at least to the *stated* values of the speaker. This means that the listener must respond to the speaker's values in the speaker's own terms. If you can respond more specifically to the speaker's values and to the feelings associated with them, you will be making a Level Three response. After practice you will be able to apply all the principles of responding you have learned so far: specific labeling of feelings and sources, responding to conflicts, and responding to values. Then you will be responding to the speaker's *total* experience.

STOP — In this scale, being aware of your own values and not letting them enter into your response is *very* important. Nothing shuts off a speaker more quickly than making judgments about what he cherishes and lives for. (Remember the roadblocks discussed in the Owning of Listener Feelings section.)

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RESPONDING-TO-VALUES SCALE

LEVEL ONE: The listener does not facilitate the speaker by—

- *judging*, agreeing with, disagreeing with, or moralizing about the speaker's values;
- *ignoring* the speaker's values;
- responding to the speaker's values using *less specific* terms than the speaker uses or generalizing to examples outside of the speaker's world.

LEVEL TWO: The listener facilitates the speaker by—

- reflecting the *stated* values of the speaker by using the same or similar words;
- responding to the speaker's values but *not* to the *feelings* associated with them;
- using examples that are *meaningful* to the speaker.

LEVEL THREE: The listener facilitates the speaker by—

- responding *more specifically* to the speaker's values;
- responding to the speaker's stated values and checking out other *undercurrent* values that may be present but not clearly stated;
- responding to the *feelings* associated with the speaker's values.

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S.E.E. 13

My father is an alcoholic and I really want to help him. It tears me apart to see what's happening at home. My mother yells and cries all the time and my brother never comes around anymore. I hate the way we're not close anymore. I just don't know what to do. My brother says to leave my father alone—that he won't change. But I really want him to change, to stop hurting himself and us too. I've been trying to get him to see a counselor, but he won't go.

I hear that you want everything to be okay at home but I agree with your brother—forget your old man. Your life is more important now.

1. What level of responding is this? _____

It sounds like it's really important to help your father so you'll all be close again.

2. What level of responding is this? _____

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I hear you saying that you really love and cherish your father and your whole family and that it's really painful for you to see them being hurt. It sounds like it's really important to help your father stop drinking and restore that family harmony again, so you're trying to convince your father to see a counselor. You sound helpless and confused about how to do that.

3. What level of responding is this? _____

S.E.E. 13 ANSWERS

1. Level One. The listener responds to the speaker's values using less specific terms ("you want everything to be okay at home") and judges him by disagreeing with what the speaker values, projecting his own values on to him ("your life is more important").

2. Level Two. The listener responds to the speaker's stated values using the same words used by the speaker ("help your father to stop drinking").

3. Level Three. The listener responds to speaker's values more specifically ("help your father stop drinking"), the feelings associated with those values ("love," "painful"), and checks out other values ("cherish your father and family," "restore family harmony"), and even checks out undercurrent feelings ("helpless and scared").

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Taped Exercise

You are now ready to practice Responding to Values (Section 1) with the tape recorder. You will hear a speaker presenting a problem. This will be followed by three separate listener responses that you will be asked to rate according to the Responding-to-Values Scale. You will repeat this process three times; then you will be asked to make up your own responses to a prerecorded problem.

S.E.E. 14

Specify whether the following statements are true or false. Circle the correct answer.

1. T F In a Level One response to values, a listener ignores the speaker's values, judges the speaker's values, or uses less specific terms than the speaker.

2. T F A listener should be aware of his own values so that they don't get in the way of responding to the speaker's values.

3. T F In a Level Two response to values, a listener responds to a speaker's values using the same or similar terms.

4. T F A Level Two or Level Three response to values should be nonjudgmental.

5. T F In a Level Three response to values, a listener responds more specifically not only to the speaker's values but also to the feelings associated with those values.

S.E.E. 14 ANSWERS

All five statements are TRUE.

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FEELINGS, VALUES, BEHAVIORS, AND PROBLEM SOLVING

Before we consider Problem Solving, where we will help the speaker sort out all the forces at work for him in a given problem situation, it will be helpful to look at values from another perspective. When we considered "clues" to a speaker's values, we discussed symbols used by the speaker to designate his values. We might call those symbols "value objects." Often, when a speaker talks about a suntan, car, job, etc. as being important, what he is really saying is that there is something larger and more comprehensive that those objects represent. A suntan may be the symbol for health, attractiveness, or a sense of well being. In the same manner, a car or job may represent security, independence, success, or accomplishment.

PERSONAL VALUES

To help illustrate this we'd like you to look at some values in the context of your own life. Following is a list of common values. Select three that seem the *most* important to you at this time in your life:

A comfortable life
An exciting life
A sense of accomplishment
A world at peace
Inner harmony
A world of beauty
Love
Security
Self-respect
Recognition
Friendship
Wisdom
Freedom
Happiness
Ambition
Honesty
Independence
Courage
Being capable

How are these values represented for you? How have you acted on these values recently? Have these values seemed more or less important in the past? Why?

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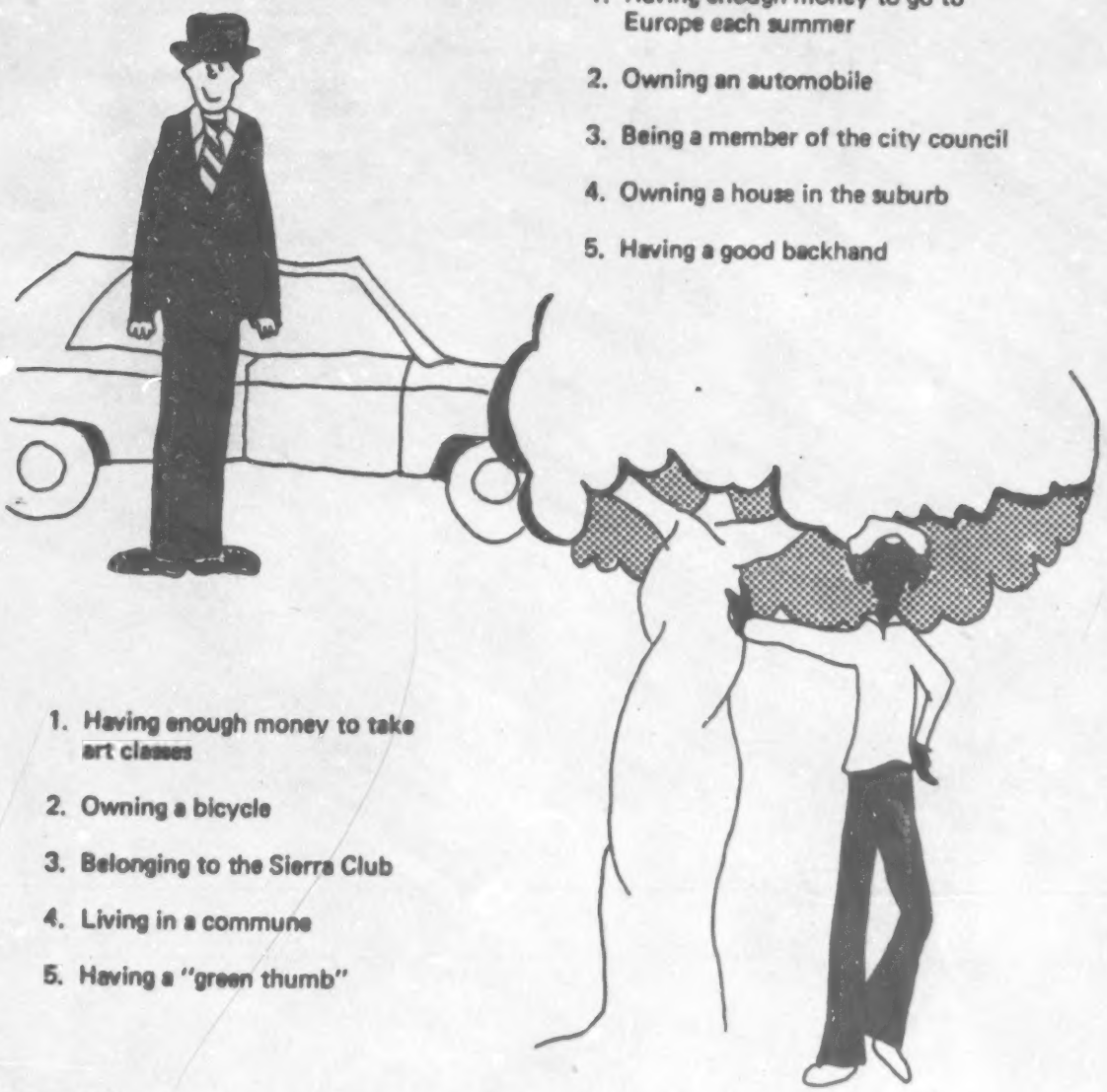
What values are represented by these two different lifestyles? Could these symbols, or value objects, be different means toward the same end?

1. Having enough money to go to Europe each summer
2. Owning an automobile
3. Being a member of the city council
4. Owning a house in the suburb
5. Having a good backhand



1. Having enough money to take art classes
2. Owning a bicycle
3. Belonging to the Sierra Club
4. Living in a commune
5. Having a "green thumb"

It is useful to consider this perspective because a speaker's values often create dilemmas for him and complicate his situation. A speaker may select value objects that are unreachable or that seem to provide more immediate pain than pleasure. His behavior may not seem to be effectively moving him toward what he does value, so be begins to feel like a gerbil on a treadmill. His values may be in conflict with his attitudes (e.g., what he thinks he should do may be opposed to what he really wants to do) or with another value (he may enjoy the love in a secure relationship that seems to stifle his sense of freedom).

When you as the listener can help the speaker explore, clarify, and understand how his feelings, thoughts, values, and behavior are integrated and interwoven, you will be helping him attain a sense of self that he may never have had before.

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MODULE 14

INTERPERSONAL PROCESS RECALL (Part II)

This module has the same purpose as Module 11, with the added element of responding to values. It provides time to practice all the skills, and is particularly useful for learning how personal attitudes and values affect one's ability to listen well and respond appropriately to a client.

There are no reading materials for this module; just follow the trainer's instructions.

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UNIT IV

PROBLEM SOLVING

INTRODUCTION

Unit IV is designed to guide you in problem solving within the helping relationship. It introduces 12 steps that are based upon the assumption that you, as listener, have responded to the speaker's feelings and values, and are now ready to help him define the problem, explore alternatives, and make and test out plans for change.

This unit contains Module 15: Problem Solving and the posttest. It will require about 6 hours to complete.

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MODULE 15

PROBLEM SOLVING

or

how to keep the mountain from coming down on you

The last part of the helping relationship deals with problem solving. After the listener has established rapport and trust with the speaker and has helped the speaker to understand how his feelings, thinking, values and behavior interrelate, the listener can assume a more active role by providing a structured way for the speaker to work on his problem.

The listener can begin to suggest places where the speaker's feelings, thinking, and behavior may or may not fit together. He can begin to encourage the speaker to try out new ways of behaving and can assist him in selecting alternatives to the ways he has tried to deal with his problems in the past. The listener can also share more of his own perceptions with the speaker. Helpful questions can be asked, and more information can be obtained and offered.

STOP The listener can take a more active part in the problem-solving process. However, his role is still *not* to solve the problem *for* the speaker. Providing solutions takes away from giving the speaker a chance to solve his problem for himself. If your solution doesn't work, then *you* have to accept the responsibility. If your solution works, the speaker can't take credit for having made the right decision.

Phrasing Questions

There are a number of additional skills that you as a listener can use to provide structure and guidance within the problem-solving process. As you assume a more active role, it is important that you avoid coming on too strong. Skillful questioning helps the speaker to provide honest and relevant information about his problem situation; it also helps him avoid responding as he thinks you want him to respond, and keeps him from using unreal or unrelated information. Using these skills with those that you have already learned (listening, understanding, communicating, maintaining a nonjudgmental attitude) helps to maintain an atmosphere of trust and rapport.

Definition 18 *Open-ended questions* are those that promote better rapport, are nonleading, and elicit more information. They do not call for multiple choice or yes or no answers, and do not require agreement with a point of view. They are not intended to make the speaker think that you already have the answer, or that you want him to see something as you see it. They invite information rather than demand an answer. Asking open-ended questions should be carefully managed to avoid generating irrelevant information.

Example: *What other feelings did you have?*

Definition 19 *Close-ended questions* are direct and call for a yes or no type answer, or very limited but specific information. They ask for simple, clear answers but limit the scope of the speaker's response. Also, they prohibit valid answers such as "maybe" or "sometimes." Close-ended questions should be used carefully, sparingly, and with a specific purpose in mind.

Example: *Does your job call for your being away from your family very often?*

Definition 20 *Probing questions* are those that are used when the speaker's responses are confusing or incomplete. Care should be taken so that the speaker does not become defensive or feel threatened. Probing questions should gently push for more information without closing off communication. (These are the type of questions you used as a recaller during the IPR.)

Example: *Can you tell me more about that?*

Guidelines for Questions

The type of question that you use will be determined by what information you are seeking and what kinds of responses the speaker is giving. There are times when close-ended questions are more appropriate than open-ended questions. The following specific guidelines should be followed, however, in asking questions during the problem-solving process:

- Ask only one question at a time.

  Ask: *When did you start using drugs?*

  Not: *When did you start using drugs and how has your problem been complicated since you started?*

- Keep questions simple. Use understandable language and avoid words that have double meanings.

  Ask: *What would be the positive and negative aspects of this alternative?*

  Not: *Can you consider the dichotomy of propitious and deleterious aspects of that trip?*

- Keep questions brief. The general rule is that a question be no longer than one sentence, with not more than one sentence preceeding it. If the question is longer, the speaker will most likely find it difficult to remember the entire question or will only answer part of it. Your first sentence may do one or all of the following: set the context for the question, provide a rationale for it, or motivate the speaker to respond to it. Here is an example.

  First sentence: *Earlier you said that whenever you tried to talk to your father about this he had a negative reaction.*

  Question: *What were some of the negative feelings you got from him?*

- Be specific. State the time, place or context you want the speaker to consider.

  Ask: *How did you feel when your brother refused to help you pay for your son's operation?*

  Not: *How would you describe your relationship with your family?*

- Ask questions in terms of the speaker's immediate experience rather than in terms of generalities.

  Ask: *How did you respond when you realized that your wife resented your asking her to help in making that decision?*

  Not: *How do you react to people not wanting to help you?*

- If the question asks for criticism, give the speaker an opportunity to voice the positive aspects before asking for the negative aspects.

  Ask: *What are the good aspects of your telling your employer you need a leave of absence?* (Wait for an answer, then ask for the negative aspects.)

  Not: *What do you stand to lose by asking your boss for a leave of absence?*

- Ask "what" or "how" questions instead of "why" questions to avoid "because" responses or responses that are vague and defensive.

  Ask: *What are some of the things that cause you to avoid solving your problem?*

  Not: *Why don't you solve your problem?*

- Ask questions that keep biased or built-in answers to a minimum.

  Ask: *How would you describe your feelings about maintaining this problem situation?*

  Not: *You seem to have some pretty self-defeating attitudes about your problem, don't you?*

- Avoid questions that ask for a simple yes or no answer.

  Ask: *Have you thought about what you will do should this alternative not work out?*

  Not: *Will you start using dope again if your plan falls through?*

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STOP There are still some other things that listeners need to learn in order to avoid pushing a speaker into a corner. The following list of behavior to be avoided is for you to look at and refer to from time to time. A listener certainly can't afford to do them *most* of the time.

LISTENER RESPONSES THAT INHIBIT BEHAVIOR*

1. Directing, Ordering, Commanding

   You must. . . . You have to. . . . You will. . . .

2. Warning, Threatening, Admonishing

   You had better. . . . If you don't, then. . . .

3. Moralizing, Preaching, Obliging

   You should. . . . You ought. . . . It is your duty. . . .

   It is your responsibility. . . . You are required. . . .

4. Persuading with Logic, Arguing, Instructing, Lecturing

   Do you realize. . . . Here is why you are wrong. . . . That is not right. . . .

   The facts are. . . . Yes, but. . . .

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*Thomas Gordon, Parent Effectiveness Training: The No-Lose Program for Raising Responsible Children (New York: P. H. Wyden, 1970).

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5. Evaluating, Judging, Negatively Disapproving, Blaming, Name-Calling, Criticizing

   You are bad. . . . You are lazy. . . . You are not thinking straight. . . .

   You are acting foolishly. . . .

6. Probing, Cross-Examining, Prying, Interrogating

   (The listener needs information, but asks too much and too aggressively.)

7. Diverting, Avoiding, By-Passing, Digressing, Shifting

   Let's not talk about it now. . . . Not at the dinner table. . . . Forget it. . . .

   That reminds me. . . . We can discuss it later. . . .

8. Kidding, Teasing, Making Light Of, Joking, Using Sarcasm

   Get up on the wrong side of the bed? . . . .

   Who do you think you are, Superman? . . . .

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The Problem-Solving Process

In the problem-solving process there are no scales to follow. Instead, there is a series of steps that assist the speaker in formulating solutions to his problem. Think of these steps as questions the speaker must consider before he can effectively work on solving his problem.

There are four major parts to this process and twelve sub-steps. The listener helps the speaker do the following:

A. Define the Problem

1. Describe the Problem
2. Clarify the Final Goal of Problem Solving
3. Describe the Forces Working for Change
4. Describe the Forces Working against Change

B. Explore Alternative Solutions

5. Identify Alternative Solutions to the Problem
6. Clarify the Reinforcements for Each Alternative Solution
7. Clarify the Punishments for Each Alternative Solution

C. Make Plans for Change

8. Organize the Order of Activities to Reach the Final Goal
9. Clarify How Problem-Solving Behavior Will Be Evaluated

D. Prepare to Act on Plans for Change

10. Identify the Initial Behavior Change
11. Identify the Initial Success Needed to Keep Trying
12. Develop a Contingency Plan to Handle the Failure of the Initial Attempt to Change

The four major parts of this process should be addressed separately and in order. Within each part, the sub-steps may be taken one at a time, depending upon what feels most comfortable or seems most logical.

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For our purposes here, however, you will learn the specific steps of the problem-solving process in order. You will then be able to practice the process within your group and receive feedback on how well you do as a listener in this process.

PART A: DEFINE THE PROBLEM

Learn the four steps in *Part A, Define the Problem* (i.e., find out what part of the mountain is coming down on the speaker).

1. Describe the Problem

By this point in the helping relationship the listener should have helped the speaker clarify both his feelings and thinking about the problem, thereby reducing an overwhelming problem to something more specific and workable. While restating feelings and thinking the listener should now also help the speaker describe what else is involved in his problem:

- The events surrounding the problem
- How often it occurs
- How long it has been happening
- The other people involved
- The speaker's behavior that leads up to or results from the problem

After the *what, when, where,* and *how* have been clarified, the listener and speaker have enough information to move to the next step.

Listener: *Let me see if I've got everything so far. You say you feel excited about the possibility for advancement by going through this training program but uncertain how you're going to be able to do that and still take care of your son. You say you're reluctant to ask your ex-wife to take care of him while you're away, because you're afraid that she will refuse.*

Speaker: *Yeah. It means a lot to me to move up in my job. In the past I missed a lot of opportunities because I was working to help put my ex-wife through law school. Now that I have the chance again I really don't want to blow it and I resent the possibility of my ex-wife not being willing to help me out.*

Listener: *I wonder if you've asked your ex-wife for help on other occasions and she's turned you down.*

Speaker: *Yeah. A couple of times I asked her to take care of Rodney for me and she really resented doing it. She said that it interferred with her career.*

Listener: *I wonder how you felt about your ex-wife resenting to do that for you.*

Speaker: *I was really mad. I felt resentful that she begrudged me the chance to better my career and I also felt guilty about putting my son in a situation where he was unwelcome and might bear the brunt of that animosity and resentment.*

Listener: *It sounds like you really care about your son and you're angry at your ex-wife because of the way she responds to Rodney as well as to yourself. What do you usually do when your ex-wife responds this way?*

Speaker: *I usually start an argument—telling her she's not being sensitive to me or responsible as a mother. We yell at each other a lot and the upshot of the whole thing is that one of us hangs up on the other and I end up not going to the training.*

Listener: *What I'm hearing is that you're anxious to take training but the responsibility for taking care of Rodney prevents you from doing that. Sounds like you feel pressured.*

Speaker: *Yeah. I feel the pressure of that responsibility. I guess the real problem is that I resent not having the freedom in my life to make decisions about my future. At the same time Rodney is my son and I feel some responsibility for his future and well-being also.*

Listener: *I wonder how you deal with all those feelings of anger, resentment, and pressure.*

Speaker: *It's important to me not to direct my anger at Rodney. So what I usually do is get drunk after I put him to bed and sit and stew, thinking that I should be more assertive. I'm afraid though that he sort of knows what's going on. Even though I try not to take it out on him, I know I'm testy the whole time the training is going on and I'm not there.*

2. Clarify the Final Goal of Problem Solving

The listener helps the speaker clarify the differences that he anticipates in his life after his problem is solved: the speaker describes how *he* wants his situation, feelings, thinking, and behavior changed. If the speaker's expectations seem too high, it's important that the listener help the speaker to realize this. After these first two steps, it might be helpful to make a problem statement—a statement of the specific problem and the final goal.

Listener: *I wonder if you've thought about how you'd like to see things change.*

Speaker: *Well, it's important for me to be able to fulfill my responsibilities as a father and part of that is going through this training so I can advance myself and make more money. I want the freedom to be able to do that.*

Listener: *It sounds like that would relieve some of the resentment.*

Speaker: *Yeah. I would start to enjoy Rodney more instead of feeling trapped and burdened by him. I want to be able to deal with my anger without sulking or drinking. I don't want Rodney to be the victim of my inability to work things out. Also, I'd like to have a better relationship with Isadora, after all she is Rodney's mother.*

3. Describe the Forces Working for Change

The listener helps the speaker sort out all the forces (rewards or "payoffs") for solving the problem. Positive feelings, better relationships, keeping a job, or saving money may be rewards enjoyed by solving the problem.

Listener: *So it sounds like if you could change this situation and resolve this problem you could have a much better relationship with your son.*

Speaker: *Yeah. Also, I could have more time for myself and my own satisfaction. It's really important to prove to myself that I can raise Rodney in a healthy environment and not feel put upon, overwhelmed, or pressured doing it.*

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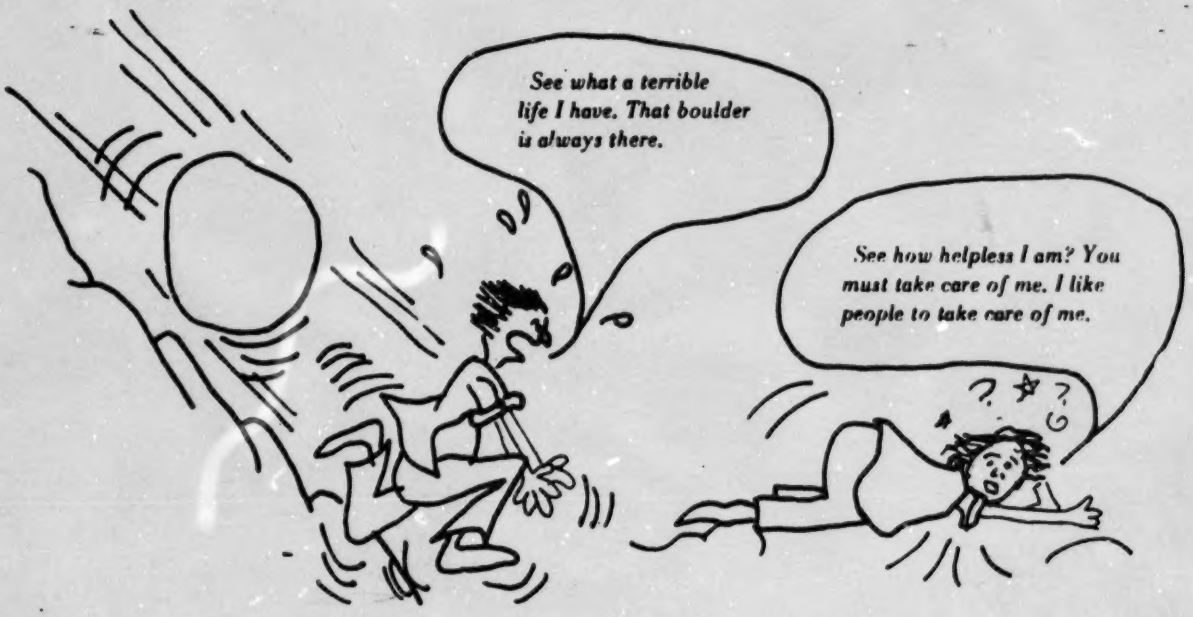
Listener: *Can you think of any other payoffs coming out of a resolution?*

Speaker: *Well, getting this training in two weeks would be a big payoff. And talking to Isadora without arguing would be a treat.*

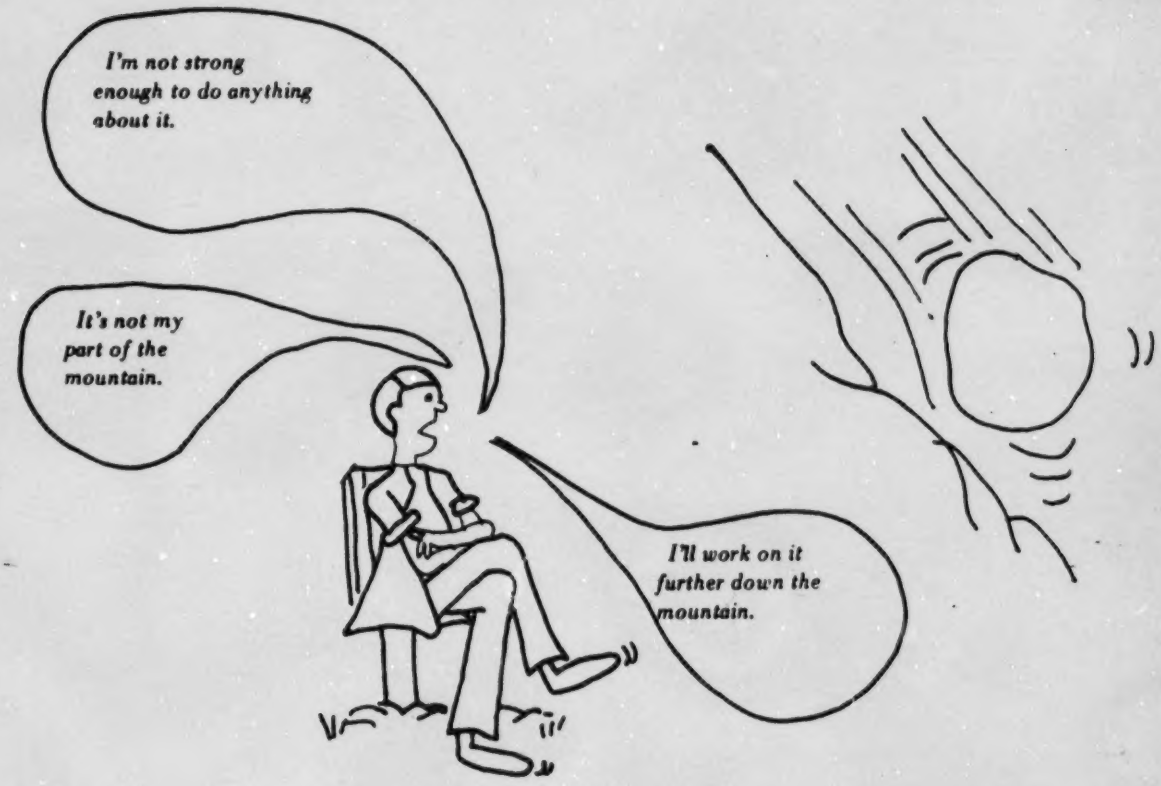
4. Describe the Forces Working against Change

The listener helps the speaker sort out all the forces that prevent him from solving the problem. Indulging in self-pity, getting sympathy from others, not having to accept responsibility for oneself, or the thrill of spending money are secondary "rewards" or "habits" that may help maintain the problem. Fear of tackling the problem, having to accept responsibility, getting used to taking the bus, or having to invest time and effort are anticipated "punishments" or inconveniences that may have to be faced in an attempt to solve the problem. It is this set of forces that may forestall the speaker's working on his problem.


See what a terrible life I have. That boulder is always there.
See how helpless I am? You must take care of me. I like people to take care of me.

After these forces have been clarified and compared to the forces working for change, the speaker will have a clear idea of both the positive and negative sides of

the problem's solution. It is important to note that the speaker may realize that what he must sacrifice to resolve the difficulty is too great a price to pay for what he gets—that at this time in his life, it's not worth it. In which case he is *stuck!*



If such is the case, however, the listener may be able to help the speaker turn his focus from the larger problem to a smaller part of the problem that is more workable. Helping the speaker make a modified problem statement with a goal that is realizeable may be necessary so that he doesn't lose his perspective and give up completely.

Listener: *You said this has been going on for some time and you've struggled with this situation before. I wonder what kinds of things get in the way of your resolving this problem.*

Speaker: *I tend to put a lot of blame on my ex-wife—bringing up all the past stuff that has never been dealt with. It's a lot easier for me to put blame somewhere else instead of dealing with myself.*

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Listener: *I wonder what you get out of keeping this problem.*

Speaker: *For one thing, I can say, if it only weren't for this, I'd have a much better position at work.*

Listener: *I'm wondering if you have any feelings that get in the way of tackling this problem.*

Speaker: *Well, on the outside I've always appeared strong and willing to accept responsibility, while on the inside I was feeling scared and uneasy. My wife on the other hand admitted openly that she wasn't ready to raise a child. Part of my fear is admitting to her—and to myself I guess—that I need some help, I can't handle it as well as I let on. It's easy to direct the anger I feel at myself to someone else, especially someone I can blame for my lot in life.*

Once the listener has helped guide the speaker through these first four steps of the problem-solving process, the speaker should have—

1. painted a much clearer picture of his problem and made a specific problem statement to work on;
2. clarified what behavior he wants to change;
3. examined the forces that are at work for change;
4. examined the forces that are at work against change.

In other words, you are looking at the mountain (problem) through the haze. You want to know what it looks like, where the boulders are, and where on that mountain the speaker is located.

Now you will be exploring each of the four steps in two ways: first by yourself, and then with a partner. Here are your instructions for the first part of practice. Choose a personal problem that you think that you want to solve. Go through each of the four steps and fill in the blanks as honestly and clearly as you can.

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Step 1. What is your problem?

(How does it show itself? When does it happen? Who else is involved when it happens? What is your behavior? What are your feelings about it?)

Step 2. What are your problem-solving goals?

(What are the rewards you expect from changing the problem? How do you expect your situation to change? How do you expect your behavior to change? How do you expect your feelings and thinking to change?)

Step 3. What are the forces working for change?

(What benefits do you expect from solving your problem? How do you expect your life to be better as a result?)

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Step 4. What are the forces working against change?

(What are the rewards for keeping the problem? What does it cost you? Is it worth it?)

Now that you have completed the steps yourself, you will sit down with a partner from your group and go through the four steps again. See if your partner, acting as a listener, can help you clarify these first four areas of your problem. Then change roles and see if you can help your partner clarify the four steps that he has gone through for his problem. During your interactions, do not use the information you have written. Remember to keep your discussion focused on *just* these first four steps.

INTERACTION TIME

Now, gather your feedback while you can! Ask your partner to fill out the following Feedback Checklist on your role as a listener to his problem (you'll be filling in his checklist while he does yours), and then talk over how you did each step. Use your written information if you wish.

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PROBLEM-SOLVING FEEDBACK CHECKLIST

	Completely?	Appropriately?
1. Was the problem defined?	_____	_____
2. Were final goals clarified?	_____	_____
3. Were rewards for solving your problem clarified?	_____	_____
4. Were rewards for maintaining your problem uncovered?	_____	_____

GROUP DISCUSSION TIME: Discuss the first four steps with your group. Your trainer will help clarify and process them. When you feel as though you understand this first section, go on to the next stage of the problem-solving exercise.

GROUP DISCUSSION

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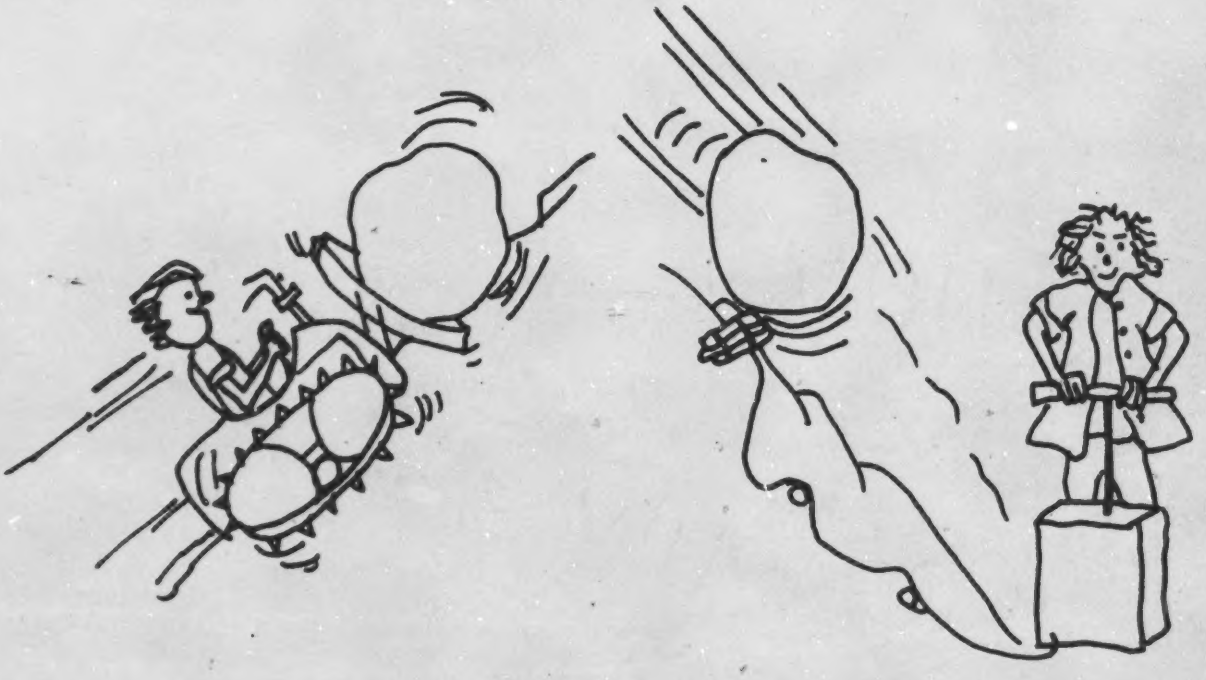
PART B: EXPLORE ALTERNATIVE SOLUTIONS

The listener and speaker explore the alternative solutions to the problem (or, how many different ways are there to stop that big rock from coming down on you?).

5. Identify Alternative Solutions to the Problem

The listener helps the speaker identify alternatives to ways he has tried to deal with his problem in the past; they brainstorm together to generate as many possible activities and ways to behave as possible. After a list of alternatives has been made, each one should be examined to determine (a) if it is possible for the speaker to perform, and (b) if it will have some affect on the resolution of the problem.



Listener: *Have you thought of any activities you could undertake to solve your problem?*

Speaker: *Well, I could sit down with my ex-wife and get everything out in the open or I could just do nothing—continue what I'm doing now but developing better ways to cope.*

Listener: *In what ways could you better cope with your situation?*

Speaker: *I could look for other resources in terms of having someone stay with Rodney. Or just resign myself to the situation but try to control my anger.*

Listener: *Is there anything else you might do?*

Speaker: *I could try to get back with Isadora, but she doesn't want a family anyway. No, I think just developing a better relationship with her would help though.*

Listener: *It seems that would involve changing some of the ways you interact with her now.*

Speaker: *Yeah, that's a two way street. I suppose if I didn't always start arguments with her, she wouldn't finish them. I'll have to start controlling my anger by not setting myself up to be on the defensive.*

6. Clarify the Reinforcements for Each Alternative Solution

The listener helps the speaker narrow the choice of alternatives that he will try by examining first the reinforcements and then the punishments attached to each. Behavior reinforcers are the rewards that the speaker may receive as a result of a particular activity or behavior. For instance, a reinforcer for refusing extra work on the job could be more leisure time and fewer feelings of pressure.

Listener: *You've identified some possible alternative solutions. What kinds of reinforcements would you get from trying each of them.*

Speaker: *I'm confused about reinforcements.*

Listener: *Well, what are the pluses for each alternative? For instance, you said you could learn to deal with your anger. What would be good about that?*

Speaker: *I'd feel a lot less uptight. I wouldn't feel guilty about taking it out on Rodney.*

Listener: *What about some of your other alternatives?*

Speaker: *Well, in terms of finding other resources, that would free me up to take opportunities when they come up.*

Listener: *You said you could develop a better relationship with your ex-wife. What payoffs could you expect from that?*

Speaker: *Yeah. I would feel like I confronted and took responsibility for my part in this problem. Plus, I wouldn't have to face the agony of calling her to ask for a favor. I think Rodney would benefit from it too.*

7. Clarify the Punishments for Each Alternative Solution

The listener helps the speaker examine the anticipated punishments attached to each alternative, what the speaker may suffer as a result of a particular behavior or activity. Some solutions may create obvious, additional problems for the speaker. For instance, admitting drug abuse to a company manager and asking for help may result in being fired. Also, the speaker may really be afraid of or overwhelmed by the thought of trying a particular behavior and may, therefore, choose another that he can undertake more comfortably.

Listener: *What kinds of punishments do you anticipate suffering by trying these alternatives?*

Speaker: *Finding other resources like a daycare center might be tough for me—in terms of the cost. Another thing is that I don't want Rodney to feel like he's being shuffled around.*

Listener: *Are there any minuses with regard to sitting down with your ex-wife and explaining your situation in order to move toward a better relationship?*

Speaker: *Sure. It's scary to think about admitting my limitations. What's really scary is that I don't know how she'll respond. But I'm also determined to get out of this rut. I would even feel worse if I didn't give it a try.*

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Now let's practice again. This section covers *exploring alternatives*. Fill in these blanks first and then practice with your partner as you did before.

Step 5. What do you need to do in order to change your problem?

(List the different ways you can change your behavior that might help resolve your problem, begin with the easiest to accomplish and finish with the most difficult.)

_____

_____

_____

_____

Steps 6. & 7. What are the rewards and punishments that might result from trying each alternative solution?

Rewards	Punishments
_____	_____
_____	_____
_____	_____
_____	_____

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Now get back together with your partner for another interaction and feedback. Exchange checklists again. Ask your partner to rate you on how well you followed steps five, six, and seven as a listener. (Do the same for him.)

PROBLEM-SOLVING FEEDBACK CHECKLIST

		Completely?	Appropriately?
5.	Were alternative behaviors for solving the problem explored?	_____	_____
6. & 7.	Were rewards and punishments attached to alternatives explored?	_____	_____

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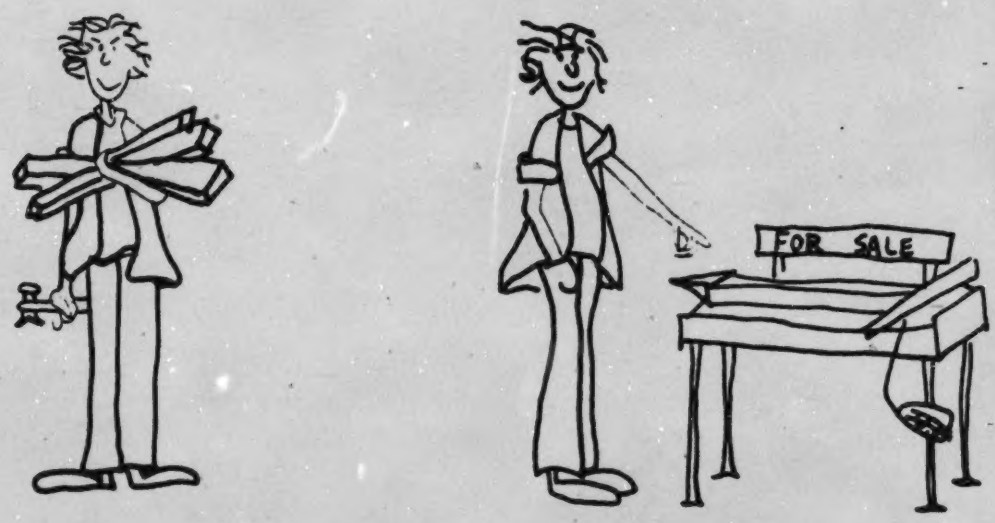
PART C: MAKE PLANS FOR CHANGE

We have found that understanding the problem and discussing ways to solve it are not always enough to help the speaker change. Hence, the next step is to encourage him to *make initial plans* that will help keep him motivated to change and accountable to himself.

8. Organize the Order of Activities to Reach the Final Goal

The listener helps the speaker devise an action plan that describes *what* he will do and *when*, *where*, and *how* he will do it in order to proceed toward problem resolution. Separating and ordering activities helps the speaker see the overall methodology in his plan and view the plan as a series of achievable steps. Describing activities in specific measureable terms will help the speaker feel accountable to each step of his plan. For instance, "I will spend *this weekend* looking for another apartment, one that I can *afford*."



Listener: *Now that you've chosen an alternative solution to work on, I'm wondering how you plan to carry it out.*

Speaker: *Well, I could tell my wife I want to take this training in two weeks. There is a real element of time involved at least with this part of the situation.*

Listener: *It doesn't seem that it's going to be that simple for you to just call her up and talk. I wonder if you've thought of how you're going to prepare for this.*

Speaker: *Well, I'm going to get drunk first. Heh, heh! No, what I need to do is to make certain what it is I'm going to say, and make certain that there's enough time to really talk.*

Listener: *How do you plan to do that?*

Speaker: *Well, I guess I have to set up a time and place that will ensure that we can talk without feeling pressured.*

Listener: *I'm wondering about the pressure you might feel right now about trying to resolve everything before your training in two weeks.*

Speaker: *Yeah. I do feel that pressure. Like I said I don't want to blow this chance. I need to settle this whole thing very soon.*

Listener: *I wonder if you're putting more pressure on yourself than you can realistically handle right now.*

Speaker: *I guess you're right. The most important thing right now is for her to agree to take Rodney for the week I'll be in training. I'll call her tonight about that and work on a long-term arrangement later.*

9. Clarify How Problem Resolving Behavior Will Be Evaluated

The listener helps the speaker identify specific ways to know whether he is proceeding toward problem resolution. This includes describing anticipated outcomes of each activity so the speaker will know if his plan is producing results. Progress can be checked after the completion of each activity listed in the action plan.

Listener: *What needs to happen in order for you to feel like you're being successful in working out this problem?*

Speaker: *Well, if I can break the ice and talk to Isadora and have her understand how important this opportunity is to me without her feeling resentful or laying guilt on me, then I would feel more hopeful and confident talking to her later about the future.*

Listener: *You said earlier that one of your goals in solving this problem is to have a better relationship with your son. What specifically will let you know that's happening?*

Speaker: *I would start to actually look forward to spending time with Rodney. And my drinking would be considerably cut down too.*

Now let's practice. Fill in these blanks.

Step 8. What activities or behavior can you list as part of an action plan?

_____

_____

_____

_____

Step 9. What are some specific things that will let you know that you were successful in those activities or that behavior?

_____

_____

_____

_____

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Join with your partner once again and take turns being a speaker and a listener. Then give each other feedback and discuss this section with the group.

PROBLEM-SOLVING FEEDBACK CHECKLIST

	Completely?	Appropriately?
8. Were activities organized?	_____	_____
9. Was an evaluation clarified?	_____	_____

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PART D: PREPARE TO ACT ON PLANS FOR CHANGE

This is the final part of problem solving. This section helps the speaker think through and prepare to test his plans.

10. Identify the Initial Behavior Change

The listener helps the speaker plan the most important step in his plan—the first one. This includes talking through *what*, *where*, *how*, and *when* the initial behavior is to take place. Also, the listener helps the speaker explore his feelings, especially fears, about proceeding with his plans to change.

Listener: *Now that you've decided on an approach, what will be your first step?*

Speaker: *I guess it's not being nasty when I call Isadora up to talk.*

Listener: *How will you do that?*

Speaker: *I'll work against being on the defensive, like calling her right away to cut down on the time pressure involved. And I'll try to be pleasant for a change. I'm afraid that she'll say no right off the bat. That might make me angry. But I'll work at not starting another argument.*

11. Identify the Initial Success Needed to Keep Trying

The listener helps the speaker identify the first success that he needs in order to continue with the problem-solving process. The awareness of this success helps the speaker avoid a sense of "going nowhere fast" and also helps put the need for instant gratification into perspective.

Listener: *What will let you know that you are being successful with this first step?*

Speaker: *If she agrees to take Rodney for the week. More important it would be not blowing up if she says no.*

12. Develop a Contingency Plan to Handle the Failure of the Initial Attempt to Change

The listener helps the speaker consider and prepare for the possibility that his first alternative will not result in success, or for the fact that there may be some unexpected stumbling blocks along the way. It is important that the speaker have another alternative to employ so that he won't feel completely defeated and lost.

Listener: *If your ex-wife refuses to take Rodney, what will you do?*

Speaker: *This training is important to me. I would probably explore another resource or just pass up the training and call her again later. If I don't blow up and start an argument, I'll leave the door open for a possible future understanding.*

Once again, join your partner and take turns being a speaker and a listener, give feedback, and hold a group discussion. Then answer the following questions.

The final practice.

10. Identify the initial behavior you will change:

(What will you do? Where will you do it? How will you do it? When will you do it?)

_____ _____

_____

_____

_____

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11. What will make you feel as though you are making progress?

(How will you reward yourself when you succeed?)

12. What will you do should your plans not work?

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Now for the final interaction and feedback:

PROBLEM-SOLVING FEEDBACK CHECKLIST

	Completely?	Appropriately?
10. Were the *what*, *where*, *how*, and *when* of the initial behavior change identified?	_____	_____
11. Were initial successes identified?	_____	_____
12. Were plans made to handle the failure of the initial attempt to change?	_____	_____

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THEORY AND RATIONALE
OF THE COUNSELING PROCESS

INTRODUCTION

The theory and rationale underlying the *Counselor Training: Short-term Client Systems* course is found in this appendix. A thorough understanding of this appendix provides the trainer with a conceptual framework for the presentation of the content of the course.

THE HELPING PROCESS

Theoretical Orientation

There are many theories, techniques, and approaches to counseling and helping relationships. Some, of course, are more effective than others, but they are all based on principles of personality theory. What makes one approach more effective than another depends largely upon the type of concern presented, the demand characteristics of the situation, and the level of skill, training, and personality dynamics of the counselor as he interacts with the client.

The helping process as defined here is broadly based upon a relationship theory of counseling, and draws from theoretical considerations of Sullivan (1953), Rogers (1957), Maslow (1962), Kell and Mueller (1966), and other writers with a humanistic orientation. Underlying the theory are the assumptions that, as human beings, we not only have the need to be understood, but also the capability to understand others. With this understanding, people can then enact powerful and meaningful problem-solving processes. The need for effective interpersonal relationships is clearly summarized by Kell and Burrow (1970)

> . . .as human beings, we need to be understood phenomenologically, or subjectively. . .the need to be understood in this way is heightened in the person seeking help with his emotional problems. At such times he has frightening feelings of apartness. . . fears of abandonment and isolation are common. . .careful listening and sensitive responses by us to these thoughts and feelings of the client help him to feel that there is someone who can know and share with him something of how he feels within himself. . .human distress is real, and must be understood and accepted as such, but it need not be devastating. Our ability to understand and perhaps to verbalize accurately the feelings of another person does not solve the problem or totally take away the distress, but it does help to rouse in him subjective feelings of hopefulness, tentative coping and thoughts of possible mastery rather than irrational despair. . . (p. 11, 12).

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Empathic Understanding

In establishing a relationship, it is important, therefore, for the counselor to be able to respond to the affective elements of the other person's concerns. Responding to another person's subjective experience is defined as empathic understanding—the ability to see the world the way the other person perceives it, that is, from his "internal frame of reference." The counselor makes an active effort to put himself in this internal perceptual world without losing his own identity or objectivity. This is accomplished primarily by thinking and experiencing *with* rather than *for* or *about* the client.

Regardless of theoretical orientation or approaches to counseling, empathic understanding appears to be a common variable that cuts across counseling effectiveness. A study by Kurtz (1970) suggested that clients' ratings of counselors' empathy, when compared to other measures of the same variables, were the best predictors of several different outcome measures. Hanson (1967) found that clients' perceptions of empathy, genuineness, level of regard, and unconditionality of regard in counseling groups were highly correlated with members' improvement in self concepts, growth of self-ideal, and self-congruence. McNally and Drummond (1973) found that ratings of counseling process and outcomes showed clients with high need for social approval rated their counselors as more empathic, and their counseling experiences as more satisfactory.

The theoretical formulations of Rogers (1961) and studies by Truax and Carkhuff (1967) have indicated that therapeutic change is related to the therapist's level of accurate empathy. Accurate empathy is thus presumed to be a facilitative dimension in helping relationships (Truax and Carkhuff, 1967; Carkhuff and Verenson, 1967; Carkhuff, 1969).

Beyond Empathy

While empathic understanding and responding are objectives for the training program, it must be emphasized that this is not all that is needed to effect productive outcomes of counseling. Without clarification of meaning, exploration of values and attitudes, and problem solving, the helping process is incomplete and usually insufficient to fully facilitate growth and movement on the part of the client.

Empathic understanding and responding facilitate clarification and exploration of the affective dynamics of the helping process and also build a foundation of trust and rapport between the counselor and the client. Responding to meaning and values and attitudes facilitates exploration of the conflicts and confusion that often surround not only client feelings, but also client thinking and behavior. Therefore, this clarification is a vital step in the progression of the helping process toward goal setting and problem solving.

A further step in the helping process is assisting the client in formulating a clear statement of goals and objectives for problem solving, and in the planning of steps to achieve these goals. This involves assisting the client in exploring alternatives and in making plans that reflect an understanding of the consequences of sustaining old behavior or risking with new behavior.

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Characteristics of Effective Counselor Behavior

Effective counselors demonstrate behaviors that support the previously mentioned elements of the helping process. When his behavior has certain characteristics, the counselor models, encourages, and facilitates constructive and positive growth in the client. These characteristics include:

- **Warmth and Caring.** Warmth is a condition of friendliness, a showing of concern and interest, and valuing the other person as another human being. Caring is closely related to warmth, but is ordinarily more enduring and emotionally intense. It means showing a deep and genuine concern about the well-being of the other person. *Caring about* another person is often confused with *taking care of* the other person. The latter connotes taking responsibility for the other person's behavior, thereby limiting his freedom to experiment and learn from his own experiences. "Taking care of" the client may also result in a very dependent relationship (e.g., parent-child), which drains the counselor's resources and constricts client growth. During the problem-solving process, however, the counselor will take a more directive and active role in facilitating the client's exploration of alternatives and their consequences.

- **Openness.** When appropriate, the counselor may need to be self-disclosing of the impact the client is having on him. The counselor may need to be aware of and share with the client his experience of the "here and now" of the interaction, taking care to bring the focus of the response back to the client (otherwise, the counselor-client roles may reverse). In the terminology of the training program, this is called counselor "owning of feelings." Appropriate use of self-disclosure is essential in building a constructive relationship, and is closely related to the element of trust. If the counselor cannot be aware of and trust his own feelings, thoughts, fantasies, values, and attitudes, it will be difficult, if not impossible, for him to facilitate similar processes in his client.

  There may be occasions when the counselor's personal dynamics interfere with or get in the way of the helping relationship. In these situations the most appropriate counselor behavior would be to "own up" to the interference and refer the client to someone else. This is particularly crucial when the client is presenting a need which goes beyond the limits of skill and experience of the counselor. "Counselor Know Thyself" is thus extended to ". . .and Thy Limits."

- **Positive Regard and Respect.** This implies not only respect for the other person's individuality, but respect for his worth as a person.

- **Concreteness of Expression.** This means that the counselor attempts to be specific rather than general or vague in his communication about feelings, meaning, values and attitudes, and problem-solving steps. Concreteness of expression also encompasses depth of exploration of client feelings, meaning, values and attitudes, and problem-solving goals. The more personal decision-making and life-survival skills the client has, the less initiative the counselor must exhibit; on the other hand, the more behavior deficits the client has, the more initiative the counselor must exhibit in facilitating the step-by-step exploration and integration of new behaviors.

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Client Growth Processes

The growth process on the part of the client involves many phases. These phases may occur at varying rates, ranging from days to years, and clients may demonstrate varying levels of success with each of these phases. The following are some of the phases that may be involved in this growth process:

- **Owning of Feelings.** The client shows immediate and free access to his feelings, expresses them in a genuine manner and is able to identify their source or origin.

- **Self-Exploration.** The client is actively and spontaneously engaged in an inward probing to discover feelings about himself and his lifespace around him. This includes his value system, his attitudes, beliefs, opinions, and his rational processes.

- **Internalization.** The client knows and trusts his feelings as belonging to him, and does not attempt to rationalize them or explain them away as belonging to something or someone outside himself.

- **Commitment to Change.** The client is deeply involved in confronting his problems directly, and clearly expresses verbally and behaviorally a desire and commitment to change his behavior. This indicates the client's willingness to take responsibility for his own behavior.

- **Differentiation of Stimuli.** The client perceives the different stimuli in his world, rather than stereotyping vaguely similar stimuli. This includes his value clarification and a restructuring of some attitudes. He differentiates between his own characteristics and those of others. He no longer says, for example, "Nobody likes me," "Why can't I be happy like everyone else," or "I'm totally inadequate at everything I do!"

- **New Behaviors are Explored and Attempted.** The client sets realistic goals for problem solving and is actively engaged in seeking alternatives suitable to himself. He experiments with new behaviors, keeping those that work and rejecting those that do not work. In effect, he has taken some interpersonal risks and discovered that actively engaging himself in new experiences is much more rewarding than passively fantasizing or worrying about outcomes.

- **Integrating New Behaviors.** Effective behaviors are incorporated into the client's current repertoire.

SUMMARY

Effective helping relationships have the same elements and characteristics as meaningful interpersonal relationships. The counseling relationship is a complex interaction of two human beings. It is not an adversary situation, where the client has all the problems and

the counselor has all the answers. When the counselor gets trapped into solving the client's problems for him, it is often because both parties are attempting to effect immediate and dramatic change. Some pressure can be alleviated if the counseling relationship is viewed as a growth process. Growth in this context means dynamic, ongoing, experiential learning where the rewards or the payoffs far outweigh the negative reinforcement.

The helping process is a two-way street, where the client is helpful by being helped, and the counselor is helped by being helpful.

This overview of the helping process offers brief theoretical constructs that the trainer may relate to in more depth and detail as the need arises. Whether a person is a counselor or a trainer of counselors, professional or paraprofessional, he will experience a constant need to know more about the behavioral sciences. One of the big rewards in the helping profession is the interrelatedness of professional development and personal growth. They complement one another just as the counselor and client complement one another in a meaningful relationship. A counselor committed to his people-helping profession leaves himself open to the ideas and experiences of his colleagues and of his clients. Trainers are thus encouraged to investigate further the research citations and reference material mentioned in this manual. Once both trainees and trainers have fully integrated an understanding of the basic helping relationship, and can apply the principles, counseling and therapeutic techniques such as behavior modification, reality therapy, transactional analysis and others can also be explored.

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FEELING WORDS

abandoned	annoyed	blah	cheated
absent-minded	anxious	blissful	cheerful
accepted	apathetic	boastful	cherished
achy	appreciative	bold	childish
active	apprehensive	bored	civilized
actualized	apologetic	bossy	clear
adamant	argumentative	bothered	clever
adaptable	aroused	bottled up	close
adequate	arrogant	boxed in	closed
adored	artistic	brave	coarse
adventurous	ashamed	broken up	cold
affected	assertive	bruised	combative
affectionate	astonished	bubbly	comfortable
afraid	astounded	burdened	common
aggravated	attached	======	competent
aggressive	attractive	caged	competitive
agreeable	awed	callous	complacent
aglow	awkward	calm	complaining
agony	======	capable	complete
alert	bad	captivated	concerned
alive	badgered	carefree	condemned
alluring	battered	careless	confident
almighty	beautiful	caring	conflicted
aloof	beaten	cautious	confused
ambitious	bereaved	certain	conspicuous
ambivalent	betrayed	challenged	conscientious
amused	bitchy	changeable	conservative
angry	bitter	charmed	considerate

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consumed
contented
contrite
conventional
cool
cooperative
cornered
courageous
cowardly
crabby
cranky
crappy
crazy
cruel
crushed
cuddly
curious
cynical
======
damned
daring
deceitful
deceived
defeated
defensive
deflated
degraded
dejected

delighted
demanding
demeaned
demoralized
dependable
dependent
depressed
deprived
deserted
desirous
despair
desperate
despondent
desolate
destroyed
destructive
determined
devoted
different
diffident
dignified
diminished
dirty
disappointed
discontented
discouraged
discreet
disdain

disgraced
disgusted
dismal
disorderly
disorganized
dissatisfied
distracted
distraught
distressed
distrustful
disturbed
divided
dominant
dominated
domineering
doomed
doubtful
down
drained
dreary
dubious
dull
======
eager
ecstatic
edgy
effeminate
efficient

egotistical
electrified
embarrassed
emotional
empathic
empty
enchanted
encouraged
energetic
enervated
enraged
enterprising
enthusiastic
envious
evasive
evil
exasperated
excited
exhausted
exposed
exuberant
======
fair
falling apart
fantastic
fascinated
fatherly
fawning

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fear	fussy	hate	imaginative
fearful	======	hateful	immature
feminine	generous	headstrong	immobilized
fidgety	gentle	heavenly	immortal
flattered	genuine	heavy	impatient
floating	giddy	helpful	important
flustered	giving	helpless	imposed upon
foolish	glad	hemmed in	impotent
forceful	gleeful	hesitant	impressed
foresighted	gloomy	high	incompetent
forgetful	glowing	hollow	incomplete
forgiving	good	homesick	independent
forlorn	grateful	honest	indifferent
formal	gratified	honored	industrious
forsaken	greedy	horrible	infantile
fortunate	grief	horrified	infatuated
forward	grim	hostile	informal
frank	groovy	humiliated	infuriated
frantic	grouchy	humorless	ingenuous
free	guarded	humorous	inhibited
friendly	guilty	hurried	inspired
frightened	gullible	hurt	insecure
frivolous	======	hyper	insignificant
frozen	happy	hysterical	insulted
frustrated	hard	======	intelligent
full	hard-headed	idealistic	interested
funny	hasty	ignorant	intimate
furious	hassled	ignored	intimidated

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intolerant
inventive
involved
irked
irresponsible
irritable
irritated
isolated
=======
jammed up
jealous
jittery
jolly
joyous
judged
jumpy
=======
keen
keyed up
kinky
kind
=======
laconic
lazy
lecherous
left out
leisurely
let down
licentious
light
little
lively
logical
lonely
longing
loose
loud
loving
low
loyal
lustful
=======
mad
malicious
masculine
mature
maudlin
mean
meek
melancholy
mild
mischievous
miserable
mixed up
modest
moody
motherly
mournful
mystical
mystified
=======
nasty
natural
naughty
nervous
nice
noisy
nostalgic
numb
nutty
=======
obliging
obnoxious
obsessed
odd
offended
omnipotent
open
on edge
opposed
optimistic
organized
out of control
outraged
outspoken
outgoing
overburdened
overjoyed
overwhelmed
=======
pain
pampered
panic
parsimonious
paralyzed
patient
peaceful
peculiar
peeved
persecuted
persistent
pessimistic
petrified
pitiful
pity
pissed
phony
pleasant
pleased
poised
polished
potent

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powerful
powerless
praiseworthy
precarious
precise
prejudged
preoccupied
pressured
pretty
prim
prissy
progressive
proud
prudish
pulled apart
put down
puzzled
---
quarrelsome
queasy
queer
quiet
---
rational
rattled
realistic
reasonable
rebellious

reckless
reflective
refreshed
rejected
relaxed
reliable
relieved
remorseful
renewed
repulsed
resentful
reserved
resourceful
respected
responsible
responsive
restless
retiring
reverent
revengeful
revived
rewarded
righteous
rigid
robbed
rotten
rude
ruined

---
sad
safe
sarcastic
sated
satisfied
scared
screwed (up)
secure
self-centered
self-conscious
self-confident
selfish
sensitive
sentimental
separate
serious
servile
settled
severe
sexy
shaky
shallow
sharp
shattered
shiftless
shocked
shook up

show-off
shrewd
shy
sickened
silent
silly
simple
sincere
skeptical
skittish
slick
slow
sly
small
smothered
smug
sneaky
snobbish
sociable
soft
solemn
soothed
sophisticated
sorrowful
sorry
special
spineless
spiteful

spontaneous
spunky
squelched
stable
startled
starved
steady
stern
stifled
stimulated
stiff
stingy
stolid
strained
strangled
strong
strung out
stubborn
stuffed
stupid
stunned
stupefied
subdued
submissive
suffering
suffocated
sulky
superstitious
sure
surprised
suspicious
sweet
sympathetic
=======
talkative
tearful
temperamental
tempted
tenacious
tender
tense
tentative
terrible
terrified
terrific
thankless
thankful
thoughtful
threatened
thrilled
thrifty
thwarted
tickled
tight
timid
tired
together
tolerant
torn
tormented
tortured
touched
touchy
tough
trapped
tricked
troubled
trusting
turned on
=======
ugly
unaffected
unambitious
unassuming
uncertain
undependable
uncomfortable
understanding
uneasy
unemotional
unexcitable
unfriendly
unhappy
uninhibited
unimportant
unintelligent
unkind
unselfish
unsettled
unscrupulous
unstable
upset
uptight
used
=======
valued
vehement
vindictive
violent
vital
vivacious
vulnerable
=======
warm
wary
wasted
weak
weepy
whiny
whipped
wholesome
wicked

902

wiped out	witty	worthless	yearning
withdrawn	wonderful	-------	-------
wise	worried	yellow	zany

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CT:STCS – A MULTI-PHASE PROGRAM FOR TRAINING OF TRAINERS

The methodologies utilized in the delivery of the *CT:STCS* course are primarily experiential skill-building processes and depend largely on the modeling and shaping process carried out by the trainer and the materials. The course is trainer-dependent. More than a manual and cassette tape are necessary for skill building. The trainer sets and maintains the climate for learning and implements specific strategies that carry out and maintain the concepts of the course.

In an effort to maintain standards of performance and the quality of counseling-skills training and to systematically increase the number of qualified *CT:STCS* trainers in the field, NDAC has devised a four-phase process by which persons would become trained and recognized as *CT:STCS* trainers.

These four phases of training are as follows:

Phase I: Successful completion of the Counseling Skills modules of the *CT:STCS* course involves attendance at all sessions of the course and attainment of the course objectives as measured by the *CT:STCS* posttest.

This phase should be considered prerequisite for any trainer anticipating training *CT:STCS*. Experience as a trainee in the small group will provide invaluable insight into the theoretical and structural design of the course, the impact of the training experience on trainees, and correct modeling behavior of the trainer.

Phase II: Successful completion of the *CT:STCS Training-of-Trainers* course entails attendance throughout the *CT:STCS/TOT* course and attainment of course objectives as measured by conceptual understanding tests as well as performance measures.

Phase II provides focused study in the theoretical and conceptual bases of the course and allows practice delivery of all elements of the course in a laboratory setting. Feedback from the Phase II trainer and fellow Phase II trainees helps to polish training skills.

Phase III: This supervised training delivery of the Phase I course requires that the apprentice trainer deliver at least 51 percent of the course content under the tutelage of a master trainer.

This type of on-the-job training prepares the apprentice trainer in all elements of Phase I delivery, including pre- and posttraining tasks, small group facilitation, and on-the-spot course modification for special circumstances.

Phase IV: This is supervised training delivery of Phase II, *CT:STCS/TOT* to other apprentice trainers.

The goal of Phase IV is to assist and prepare the trainer to deliver Phase II, to anticipate the concerns of apprentice trainers who are about to be trained in Phase I for the first time, and to provide additional trainer tips regarding the content, process, and design of Phases II and III.

This multi-phase system will then provide four levels of mastery for *CT:STCS* trainers:

Potential trainer: a trainer who has completed Phase I and who meets the general trainer requirements*

Apprentice trainer: a trainer who has completed Phases I and II

Senior trainer: a trainer who has completed Phases I, II, and III

Master trainer: a trainer who has completed all four phases and who has extensive experience training the *CT:STCS* course and supervising Phase III group leaders

A trainer who has completed these phases of training will have first-hand knowledge and experience with the conceptual framework, training goals, structure, and developmental learning stages of the course. He will be able to anticipate the impact of the training experience on the trainee, and will have experienced and dealt with, under supervision, the dynamics occurring within the small-group training.

NDAC is currently constructing curricula for the four *CT:STCS* phases, including behavioral objectives, content outline, and delivery strategy. These will be published as an additional resource that can be included as an appendix to the current *CT:STCS Trainer's Manual*. In order to publish the availability of qualified *CT:STCS* trainers already in the field, NDAC is also compiling a training directory that will include the names and addresses of persons who have completed Phases III and IV.

*Trainer requirements are noted in the *CT:STCS Trainer's Manual*.

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HOW TO ORDER MATERIALS

If you are interested in this course, or in other drug abuse related courses, write or call for more information to:

National Drug Abuse Materials
Distribution Center
Post Office Box 398
McLean, Virginia 22101
(703) 790-8229

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ANNOTATED BIBLIOGRAPHY

FOR

COUNSELING AND TRAINING

This bibliography provides a background of research and theory upon which *CT:STCS* is built.

Anderson, Dorothy B., & McClean, Lenora J. *Identifying Suicide Potential*. New York: Behavioral Publications, Inc., 1969.

Eleven symposium papers from the Conference on Identifying Suicide Potential held at Columbia University, December 1969, focus on the extent of suicide potential and the forces affecting this tendency in society at large, the family system, and specific high-risk groups.

Beck, Aaron T.; Resnick, Harvey L. P.; & Lettieri, Dan J. *The Prediction of Suicide*. Bowie, Maryland: Charles Press Publishers, Inc., 1974.

This book features selected papers that cover important aspects in defining and ascertaining the causes of suicide. They clarify the development and validation of various methods used to measure suicidal intent and risk.

Brammer, Lawrence M. *The Helping Relationship: Process and Skills*. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1973.

Three categories of helping skills—understanding, comfort, and action—are presented in precise detail in a style simple, direct, and without professional jargon. Aspects of the helping relationship covered are: characteristics of helpers, the helping process, listening skills, teaching skills, confronting skills, and skills for comfort and crisis.

Carkhuff, Robert R. Critical Variables in Effective Counselor Training. *Journal of Counseling Psychology*, 16(3), 238-245, 1969.

Discusses trends found over 16 different studies indicating that the level of facilitative and action-oriented functioning of a trainer may be related to the level of functioning reached by a trainee. Considered also in this discussion is the level of facilitative functioning that is present initially for a trainee and the type of training program. Three

hypotheses result: (1) Trainers' levels of functioning seem most important with those trainees whose functioning is growing in the direction of the trainer. (2) Trainees seem to gain more with trainers whose own functioning is high and lose most with trainers at a low level of functioning when the difference between the trainer functioning is great. (3) Programs that seemed most effective were those that focused orderly and behaviorally upon the action-oriented and facilitative factors.

Carkhuff, Robert R. Helper Communication as a Function of Helper Affect and Content. *Journal of Counseling Psychology*, 16(2), 126-131, 1969.

Reports the results of a study done to investigate relationships between the following variables: helper's level of experience (and training); type of emotion expressed by helper; and content of helper's statement. Carkhuff examines these by first having his subjects formulate responses to videotaped helpee statements and by then having his subjects rate four different responses to each of the same helpee statements, according to how facilitative the responses are. Makes a point for experience and particularly communication training through this analysis of data. Also notes that there is a difference between discrimination of and communication of facilitative responses.

Carkhuff, Robert R. *Helping and Human Relations: A Primer for Lay and Professional Helpers*. 2 Vols. New York: Holt Rinehart and Winston, Inc., 1969.

Volume I: Selection and Training

Discusses first effectiveness of lay and professional helpers, citing research and exploring issues revolving around lay and professional programs. Part Two presents a model of human functioning and dysfunctioning, often in propositional form, as well as an effort to integrate helper's function, helper's impact, and environmental influences into a picture of helping processes. Part Three speaks to selection processes and to assessment of communication and discrimination. Part Four examines training, means for setting up effective training programs and the actual components of training, for example, scales of the facilitative and action-oriented dimensions.

Volume II: Practice and Research

Part One examines the idea that there is both facilitation and retardation potential in the helping process and then the implications of this concept. The components of effective helping are discussed in Part Two, which also broadens the focus to include group processes as well as individual. Part Three evaluates turning theory into practice and practice into theory, developing models, and basic principles of research. Part Four is an overview and summary.

Two rich volumes, written in understandable terms with concise and clear ideas about helping.

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Carkhuff, Robert R.; Friel, Ted; & Kratochirl, Dan. The Differential Effects of Sequence of Training in Counselor Responsive and Counselor Initiated Conditions. *Counselor Education and Supervision*, 9(2), 106-109, 1970.

A study designed to investigate whether or not it makes a difference to first train people on the facilitative or responsive dimension and then on the action-oriented, confrontive dimension or to reverse the order of the two dimensions. The researchers found no significant difference between the two sequences; however, given some trends in their data, they do suggest that for short training programs, the greatest changes in the least amount of time result from training counselor responsiveness first.

Carkhuff, R. R. Principles of Social Action Training for New Careers in Human Services. *Journal of Counseling Psychology*, 18, 147-151, March 1971.

An examination of the selection and training in helping and human relations skills of lay personnel indigenous to the inner-city. The advantages and disadvantages of using lay personnel as functional professionals are discussed, along with an explanation of the selection and training procedures. Results indicate that lay personnel can be used effectively in social action programs, and in addition can be used to train others.

Carkhuff, R. R., & Griffin, Andrew H. The Selection and Training of Human Relations Specialists. *Journal of Counseling Psychology*, 17, 443-450, September 1970.

This study is an attempt to meet the needs of junior high school black students. Adult blacks were systematically selected and trained. Training areas included empathy, respect, genuineness, and confrontation. These specialists were then evaluated in terms of effectiveness, and results showed they were functioning in the helping role above levels which were minimally effective.

Carkhuff has numerous other books and articles. Three of particular interest are:

The Art of Helping. Amherst, Massachusetts: Human Resource Development Press, 1973

The Art of Problem-Solving

The Art of Training

Chapman, J. L. Development and Validation of a Scale to Measure Empathy. *Journal of Counseling Psychology*, 18, 281-282, May 1971.

An attempt to develop a measuring scale for affective sensitivity. The author used several videotaped recordings of interviews and tested a subject's ability to identify

emotions expressed by another person. Results were not significant enough to differentiate between experimental groups and the predictive validity of the instrument was nonexistent.

Danish, S. J., & Kagan, N. Measurement of Affective Sensitivity: Toward a Valid Measure of Interpersonal Perception. *Journal of Counseling Psychology*, 18, 41-54, January 1971.

This study is an attempt to build on evidence from previous research that indicates personal growth in interpersonal sensitivity is reflected in the Affective Sensitivity Scale. This scale was able to pick up differences in affective sensitivity for both intensive and long-term training programs. The authors concluded that this scale may meet some of the necessary conditions to measure personal growth in counselor training programs and other experiences designed to improve interpersonal sensitivity.

Dugger, James G. *The New Professional: Introduction for the Human Services and Mental Health Worker*. Monterey, California: Brooks and Cole Publishing Company, 1975.

An introductory textbook for students in human services and mental health programs, it describes the newly emerging manpower source in the human services and provides a basic understanding of the notes and functions performed by this new generalist worker.

Fisher, Sheila A. *Suicide and Crisis Intervention: Survey and Guide to Services*. New York: Springer Publishing Company, 1973.

A national research and survey guide defining and synthesizing material concerning both common and unique methods and techniques of operation of suicide and/or crisis prevention services. Some of the areas discussed concern purposes, goals, sponsorship, funding, recruiting, staffing, training, and community involvement.

James, Muriel, & Jongeward, Dorothy. *Born to Win: Transactional Analysis with Gestalt Experiments*. Reading, Massachusetts and Menlo Park, California: Addison-Wesley Publishing, 1971.

Examines the approaches of Frederick Perls and Eric Berne to understanding human behavior, and provides integration of the two approaches. The general focus is enhancing awareness, self-responsibility and genuineness. Exercises designed to help the reader experience the content of the book more directly are presented at the end of each of the book's ten chapters. Related references are also provided for each chapter.

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The book is designed for use by individuals "interested in personality theory and interpersonal relationships," for example, people in teaching, mental health fields, and management. Gives the background in theory and practical applications for gestalt theory as interpreted by Perls and transactional analysis as developed by Berne. Not a formal test of psychotherapy; uses many examples from less formal relationships and situations. The authors state a philosophy that man is able to modify both heredity and environment.

Jordan, David Lee. A Comparison of the Effects of Didactic and Experiential Training on Accurate Empathy, Non-possessive Warmth and Genuineness. *Dissertation Abstracts International*, 29(9-B), 3487-3488, 1969.

Jordan compares three groups: a group receiving group therapy with high levels of empathy, warmth and genuineness present, a group receiving specific training to increase levels of empathy, warmth and genuineness within individual therapy, and a group receiving no treatment. Jordan found no significant differences between the group therapy subjects and the specific training subjects. However, specific training made significantly more change than the no-treatment group on all dimensions. At issue here is the "opportunity to imitate good therapy," present in both treatment groups, and receiving more emphasis in the specific training group.

Kagan, Norman; Schauble, Paul; Resnikoff, Arthur; Danish, Steven J.; & Drathwohl, David R. Interpersonal Process Recall. *Journal of Nervous and Mental Disease*, 148(4), 365-374, 1969.

Description of interpersonal process recall, its use in both psychotherapy and training of counselors. Recall sessions are conducted by a third individual, who is called an "interrogator" in this article. An explanation of his role, how he is trained and how the authors arrived at his use is provided. Also included is information on set-up and facilities. The paper is descriptive of the IPR technique as it was originally developed at Michigan State University.

Kagen, Norman. *Influencing Human Interaction*, 1972.

A training manual that includes all scripts from a videotape training program and also instructions to trainers. Begins with elements of therapeutic communication and continues through counselor self-studies and the mutual recall process. May be obtained by writing the author, Department of Counseling, Personnel Services, and Educational Psychology, Erickson Hall, Michigan State University, E. Lansing, Michigan 48823 ($10.00).

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Kell, Bill T., & Burrow, Josephine Morse. *Developmental Counseling and Therapy*. Boston: Houghton Mifflin Company, 1970.

Therapy is presented as "having to do with the repair of some failure in the developmental process." Antecedent, interpersonal relationships are seen as the primary factor in developmental failure. The provision of a new interpersonal relationship in the counseling process is regarded as the primary factor in the repair.

Klagsbrun, Francine. *Too Young to Die*. Boston: Houghton Mifflin Company, 1976.

Straightforward, nonsensational information about youthful suicides. Drawing on a vast amount of scholarly research, clinical tapes, and conversations with suicidal young people and their friends, the author presents a picture of the myths and realities of suicide. She explores motives and underlying causes, describes the symptoms of depression, and suggests how anyone can offer aid in a suicidal crisis.

Mallot, Richard W. *Contingency Management*. Kalamazoo, Michigan: Behaviordelia, 1971.

Presents examples of behavior modification in easy to understand comic book form using self tests at the end of each chapter on behavioral principles. Paperback: $4.00

Marks, H. E. The Relationship of Eye Contact to Congruence and Empathy. *Dissertation Abstracts International*, 32, 1219, August 1971.

An examination of eye contact and its relation to congruence and empathy, with the prediction of more congruence and empathy for those better able to maintain eye contact. The results confirmed the hypothesis, with training having no significant effect on increasing either variable. Implication for eye contact in therapy was explored.

Moriarty, Robert V. Counselor Trainee's Perceptions of Affective States and Empathic Understanding in Training Performance. *Dissertation Abstracts International*, 32, 3033, December 1971.

This study focused on the affective sensitivity of counselor trainees and their empathic understanding in a controlled counseling setting. The Affective Sensitivity Scale was administered as a pre- and posttest to: (1) a group of students in an introductory guidance and counseling course; and (2) trainees in a counseling practicum. Comparisons were made of the performance on the Affective Sensitivity Scale on the dimensions of sex and level of training. Results indicated no significant relationship on all dimensions except sensitivity and assessed empathic understanding of counselor trainees.

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Resnikoff, Arthur; Kagan, Norman; & Schauble, Paul G. Acceleration of Psychotherapy through Stimulated Videotape Recall. *American Journal of Psychotherapy*, 24(1), 1970.

A case study of a fairly disturbed student, into whose course of therapy interpersonal process recall was introduced. Discusses both details of the case and details of the recall, which occurred at the 12th of 20 sessions with this client. Independent observers were asked to rate the client's behavior from session 9 through session 15, with no knowledge that IPR had been introduced. Results lent support to the idea that the use of IPR had influenced gains in the client's behavior. An attempt was also made to "develop a valid process instrument that would record client progress within the interview situation."

Rogers, Carl R. *Client Centered Therapy*. Boston: Houghton Mifflin Company, 1951.

A classic presentation of nondirective, client oriented counseling and therapy, that considers the psychology of the self and the nature of the maladjustment of modern man in his social environment.

Shapiro, Jeffrey G.; Krauss, Herbert H.; & Truax, Charles B. Therapeutic Conditions and Disclosure Beyond the Therapeutic Encounter. *Journal of Counseling Psychology*, 16(4), 290-294, 1969.

A study addressing itself to the issue of whether or not genuineness, warmth and empathy from another elicit self-disclosure on the part of an individual outside of a formal therapeutic, professional relationship. Discusses also the type of self-disclosure, that is, positive or negative feelings, verbal or behavioral self-disclosure. The researchers had their subjects rank both parents and two close friends on the basis of perceived genuineness, warmth and empathy and then asked for amount and type of self-disclosure to these four individuals. Results lend support to the notion that individuals tend to be more open with those people they perceive as genuine, warm and empathic outside of a formal therapeutic relationship.

Shaw, Sara F. Empathy and Its Relationship to Selected Criteria of Counselor Effectiveness. *Dissertation Abstracts International*, 31, 163, July 1970.

An investigation of the use of an interaction analysis scale (Counselor Self-Interaction Analysis) for the development, measurement, and prediction of empathic understanding. In addition, the relationship between counselors' in-training self-concept, supervisor's ratings of counselor effectiveness, and two measures of empathy (Accurate Empathy Scale and Affective Sensitivity Scale) were examined.

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Staub, George E., & Kent, Leona M. *The Paraprofessional in the Treatment of Alcoholism*. Springfield: Charles C. Thomas, 1973.

This multi-authored book covers a wide range of philosophies and policies related to working with and as a paraprofessional in the field of alcoholism. Such subjects as in-service training, nonalcoholic vs. "recovered" personnel and the role of the administrator are covered.

Swenson, Charles D. The Relationship between Certain Personality Traits of Advanced Counselor Trainees and Their Ability to Express Congruence, Empathy and Positive Regard. *Dissertation Abstracts International*, 31, 1027-1028, September 1970.

An investigation of the relationship between the counselor's ability to express conditions for positive growth in the therapeutic situation and certain personality characteristics. The experimenter used Truax Scales and Counselor Verbal Response Scales to examine the relationship between these characteristics and empathy, congruence, and positive regard. Conclusions and implications of the study are listed.

Truax, Charles B. An Approach to Counselor Education. *Counselor Education and Supervision*, 10, 4-15, Fall 1970.

A training approach applicable to both professionals and nonprofessionals with emphasis on selection and training through structured practice experiences. A brief review is made of research indicating the major ingredients of effective counseling, listing basic interpersonal skills of warmth, genuineness and accurate empathy as important.

This selection procedure recommended involves (1) a candidate meeting the agency's existing qualifications, (2) the use of past research findings regarding personality characteristics of good counselors, and (3) ratings of candidate's interpersonal skills based on group interviews with real clients.

The training program emphasizes feedback and systematic evaluation of the effect a counselor has on his clients. The basic elements of the training are (1) modeling of proper interpersonal skills in supervision, (2) didactic training of proper skills, and (3) a group therapy experience. He proposes that nonprofessionals can be better selected than professionals and can be equally trained.

Truax, C. B. Length of Therapist Response, Accurate Empathy, and Patient Improvement. *Journal of Clinical Psychology*, 26, 539-541, October 1970.

An investigation of whether the average number of therapist's words per unit of time is related to: (A) his degree of accurate empathy and (B) patient improvement during

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therapy. The accurate empathy scale and several measures of patient improvement were used. The data indicates a moderate positive relationship between the average proportion of therapist talk and his level of accurate empathy, and between therapist talk and overall patient improvement.

Truax, C. B. Self Disclosure, Genuineness, and the Interpersonal Relationship. *Counselor Education and Supervision*, 10, 351-354, Summer 1970.

Previous studies have generally found that accurate empathy and nonpossessive warmth are most highly related to client's level of self-disclosure, but those studies assumed interaction was a "one-way street." Truax extends these findings to examine the concept of reciprocal affect, that what we offer another person we elicit from them. Recent research is cited that supports that genuineness or congruence is directly causative of therapeutic client change and that self-disclosure is a necessary condition for the development of genuineness. Although evidence is consistent, Truax concludes that it does not provide direct confirmation of this assumption.

Truax, C. B., and Lister, J. L. Effects of Short-Term Training upon Accurate Empathy and Nonpossessive Warmth. *Counselor Education and Supervision*, 10, 120-125, Winter 1971.

This study is based on previous research that demonstrated that the interpersonal skills of accurate empathy and nonpossessive warmth are highly important in the counseling interaction. The researchers attempted to determine whether significant improvement in accurate empathy and nonpossessive warmth could be effected over a 40-hour training period, using an experiential-didactic training approach with experienced counselors.

Results showed a significant increase in accurate empathy for counselors who were initially high or low on empathy (N = 12). There was no increase in nonpossessive warmth, and some indication of a decrease for counselors initially high with warmth. These results were compared with other studies and supported the hypothesis that gains on these dimensions occur after the initial graduate training program.

Vriend, John, & Dyer, Wayne W., Editors. Group Counseling: Part One; and Group Counseling: Part Two. *Educational Technology*, January and February 1973.

Two special issues compiling the most current technology and research in group counseling techniques. Describes both group leader and group member behavior. A very complete collection of articles in this field. Can be ordered at $6.00 for both issues by writing: Educational Technology Publication, Inc., 140 Sylvan Avenue, Englewood Cliffs, New Jersey 07632.

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Weisman, Thomas. *Drug Abuse and Drug Counseling, A Case Approach*. Cleveland, Ohio: Press of Case Western Reserve University, 1972.

Book is in workbook format and involves the participation of the reader. Each of the seven chapters (narcotic analgesics; alcohol; hypnotics and tranquilizers; amphetamines and cocaine; hallucinogens; marijuana; caffeine and nicotine) includes background information, true-false self-test followed by explanations, and brief case outlines with possible courses of action. A complete annotated bibliography is included for each section.

Yenawine, G., & Arbucle, D. S. Study of the Use of Videotape and Audiotape as Techniques in Counselor Education. *Journal of Counseling Psychology*, 18, 1-6, January 1971.

This study compares and contrasts the effects of using audiotape and videotape recording techniques on counselor trainees within the counseling practicum. Data was gathered from two groups of students primarily by the use of a counselor log. The similarities and differences are noted and several conclusions stated about the appropriateness of use for each technique.

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Methodology

The course is designed to be delivered in five seven-hour training days (33 hours). The learning activities are sequential and developmental and occur almost entirely in small groups of five or six. Concept building is followed by discrimination exercises and structured interactive exercises.

Personnel Requirements

The small-group work must be conducted by a trainer or training team with a maximum trainer/trainee ratio of one to six. Every member of the training team should have successfully completed the course as a participant, received training of trainers specific to this course, and have co-trained the course with an experienced trainer. In addition, the trainer should have had previous experience in counseling and small-group process and training skills.

Course Materials

Training Manual for Counseling Skills

Trainer's Manual

Audio Cassette

Evaluation Instruments (included in *Trainer's Manual*)

Equipment

The following equipment will be needed:

- One cassette tape recorder with live recording capabilities per small group
- One blank cassette tape per small group
- Flip chart easels and pads and markers
- One ½ inch videotape camera, recorder, and monitor per small group (optional)
- One blank ½ inch videotape per small group (optional)

Facilities Needed

The facilities needed for this course are the following:

- One large group meeting area
- One small group work area per five to six participants

Time Requirements

Five days (33 hours)

PLAN OF INSTRUCTION/LESSON PLAN PART I

NAME OF INSTRUCTOR	COURSE TITLE
	Drug and Alcohol Abuse Control

BLOCK NUMBER	BLOCK TITLE
II	Skills and Knowledges

1 COURSE CONTENT	2 TIME

4. Alcohol Pharmacology

a. Identify the physical and psychological effects of alcohol in humans.

SUPPORT MATERIALS AND GUIDANCE

Student Instructional Material
SW B-II-5-9, Alcohol Pharmacology

Audio-Visual Aid
35mm Slides, Alcohol Pharmacology

Training Methods
Lecture
Discussion

Instructional Guidance
Emphasize the proper classification of alcohol and compare its actions on the body with other drugs in the same class. Discuss the bodily processes involved in the absorption, distribution, and metabolism of alcohol and how each effects response. Describe the short- and long-term (chronic) effects of use. Cover the major stages of withdrawal and the associated symptoms. Stress withdrawal as a potential medical emergency. In small groups, answer student questions, elaborate on specific items, and clarify misunderstandings.

SUPERVISOR APPROVAL OF LESSON PLAN (PART II)

SIGNATURE AND DATE	SIGNATURE AND DATE

PLAN OF INSTRUCTION NUMBER	DATE	PAGE NO.
L3ALR73430B/L30LR7361B/L30ZR7364B	30 May 1978	21

ATC FORM OCT 75 133 PREVIOUS EDITION IS OBSOLETE

PART II - TEACHING GUIDE

INTRODUCTION (5 Minutes)

ATTENTION

Alcohol is the most universal drug known to man. Its use extends from social drinking to alcoholism. Alcohol comes in different forms, each equally effective. The form of alcohol used is merely a matter of tast, cost, and the need for effect. Alcohol, itself, is neither a "safe" nor a "dangerous" drug. Its benefit or detriment is determined by the manner in which it is used.

MOTIVATION

Alcohol abuse has reached epidemic proportions in this country. Partly because of its easy accessibility, limited legal implications, and general acceptability of use in our society,

alcohol is becoming a popular alternative to other drugs of abuse. In recent years, more and more younger alcoholics have been identified. A basic understanding of alcohol pharmacology is essential in dealing with the problems of alcohol abuse.

OVERVIEW

1. Read the lesson objectives to the class.
2. Develop the lesson chronology.
    a. Alcohol terms and characteristic actions.
    b. Factors influencing alcohol's effects.
    c. Acute physiological effects of alcohol.
    d. Chronic disorders of alcohol abuse.
    e. Stages of the alcohol withdrawal sequence.

BODY (2 Hours 45 Minutes)

PRESENTATION

6a. CRITERION OBJECTIVE: Identify the pharmacologic classification of alcohol and four drug actions it shares with other members of its class.

1. Explain that the term "alcohol," used here, denotes ethyl alcohol or ethanol.

2. Explain that alcohol is classified as a central nervous system (CNS) depressant, sedative-hypnotic, same as the barbiturate and non-barbiturate sedative-hypnotics.

3. Explain that alcohol shares four characteristic actions with the other drugs in its class.

a. Drug dependence.

(1) Both psychological and physical dependence occurs.

(2) It involves the amount, the frequency and

duration of use, and the personal makeup of the individual.

b. Tolerance requires that larger doses be taken to produce the same effect.

(1) It provides a basis for physical dependence.

(2) It does not change the lethal dose.

c. Cross-tolerance allows for substituting the effects of one for another within the same class.

(1) The combined use of two or more drugs within the same class increases the risk of toxicity.

(2) This characteristic is used in treating alcohol withdrawal.

d. Withdrawal.

(1) It can be stopped or lessened by substituting another drug of the same class as the one discontinued.

(2) Barbiturate withdrawal is serious and can be fatal.

(3) Alcohol withdrawal is less serious.

EVALUATION

1. What is the pharmacologic classification of alcohol?

2. What characteristic actions does alcohol share with the other types of drugs in its class?

PRESENTATION

6b. CRITERION OBJECTIVE: Identify how absorption, distribution, and metabolism of alcohol influences the dose-time-response relationship.

1. Explain that alcohol effects are dose- and time-related.

2. Explain that pharmacodynamic processes (absorption, distribution, metabolism, and excretion) are important to the dose-time-response relationship.

a. Absorption rate determines the blood-alcohol content (BAC). BAC is measured as the milligrams (mg) of alcohol per one hundred millimeters (ml) of blood. The BAC is influenced by several aspects:

(1) Rate of alcohol consumption. (Quantity of Alcohol slide)

(2) Condition of the gastrointestinal (GI) tract.

(3) Type of drink.

b. Distribution carries alcohol to different parts of the body. Distribution is influenced by the size and weight of an individual.

c. Metabolism terminates the action of alcohol.

(1) About 90% of the alcohol is oxidized in the liver.

(Reaction Sequence of Alcohol slide)

(2) Metabolism is influenced by enzyme stimulation.

EVALUATION

1. What are the three pharmacodynamic processes influencing the dose-time-response relationship?

2. What aspect(s) influence(s) absorption?

PRESENTATION

6c. CRITERION OBJECTIVE: Identify the six basic types of physiological effects of alcohol on the body, which may result from short-term use.

1. Explain that the physiological effects of alcohol involve the entire body, not just the CNS.

a. The effects are due to either direct or indirect actions of alcohol.

b. Many of the effects are interrelated with others.

c. The basis for most effects are either unknown, ill-defined, or controversial.

d. The effects are dose-time dependent and are influenced by different factors.

e. The effects may be grouped according to the general body function affected.

2. Explain the six basic types of physiological effects of alcohol.

a. Metabolism effects of alcohol cause changes in the production, breakdown, and storage of fats, sugars, and proteins. The main effects produced by these changes include:

(1) Increased blood sugar, or

(2) Decreased blood sugar.

(3) Increased blood fat.

(4) Fat accumulation in organs (liver, heart, muscle).

(5) Organ damage, with decreased functioning.

b. GI tract effects of alcohol include:

(1) Increased release of stomach acid juice.

(2) Irritation of GI tract lining.

(3) Interference with absorption of vitamins and nutrients (Vitamins B, C, and K; folic acid, amino acids, and others).

(4) Organ damage, with decreased functioning.

e. Endocrine effects of alcohol can change the actions of hormones, by interfering with their release, production, or breakdown. The main affects caused by these changes include:

(1) Changes in the metabolism of fats, sugars, and proteins.

(2) Sex hormone imbalance.

(3) Increased urine flow (diuresis).

(4) Potassium loss.

(5) Hormone organ degeneration.

d. Blood is affected through the effects of alcohol on other organs; e.g., GI tract. These indirect effects of alcohol result in the following:

(1) Decreased production of blood cells.

(2) Poor clotting.

(3) Decreased functioning of blood cells.

(4) Increased destruction of blood cells.

e. Renal effects result from alcohol's action on metabolism and hormones. Effects seen on the kidney include:

(1) Increased urine flow (diuresis).

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(2) Salt and water retention (edema).

(3) Electrolyte (salts and minerals) loss.

f. Temperature control effects of alcohol result in a decrease of body temperature.

EVALUATION

1. What are the six basic types of physiological effects of alcohol?

2. The renal effects of alcohol result primarily from what two basic physiological effects of alcohol?

PRESENTATION

6d. CRITERION OBJECTIVE: Identify the common systemic disorders resulting from chronic alcohol abuse and the major symptoms associated with each.

1. Explain that the type and degree of disorder depends on

the duration of abuse and the individual's biological makeup.

2. Explain that liver damage is common to alcohol abuse. Liver disorders occur, in series, as follows:

a. Fatty liver.

(1) Fat accumulates in cells, causing enlargement and decreased liver function.

(2) Damage is repairable at this stage, if alcohol use is stopped.

b. Alcoholic hepatitis, characterized by:

(1) Jaundice.

(2) Decreased liver function.

(3) Increased toxic ammonia in blood.

(4) Swelling of the liver.

(5) This condition can lead to total liver failure,

followed by coma and death. If alcohol is stopped, the liver will repair itself.

c. Cirrhosis is the final stage of liver damage.

(1) Degree of cirrhosis can vary.

(2) The damage is not reversible.

3. Explain that CNS disorders are common and often associated with metabolic changes and nutritional deficiencies.

a. Alcoholic neuropathy.

(1) Involves nerves' control of muscle (mostly in the lower extremities -- numbness, weakness, cramps, paralysis).

(2) Results from Vitamin B deficiency and fat accumulation in muscle.

(3) Effects are reversible, to some extent, with treatment.

b. Wernike's encephalopathy.

(1) Involves impaired mental processes and inability to control muscles.

(2) Results from Vitamin B deficiency.

(3) Effects are reversible, to an extent, with treatment.

c. Jolliffe's encephalopathy.

(1) Similar to Wernike's.

(2) Results from niacin deficiency.

(3) Treatment with niacin reverses some symptoms.

d. Korsakoff's psychosis.

(1) Severe mental malfunction and brain damage.

(2) Results from nutritional deficiencies and metabolic changes.

(3) Effects are not reversible.

e. Marchiafava's disease.

(1) Similar to Korsakoff's.

(2) It is not reversible.

(3) Diagnosis is made at autopsy.

4. Explain that the GI tract disorders are attributed to the irritation of the GI tract lining and increased stomach acid release caused by alcohol. The disorders include:

a. Ulceration and scarring of the tract lining.

b. GI tract bleeding.

c. Inflammation of the stomach.

d. Inflammation of the pancreas.

e. Poor absorption.

5. Explain that the blood disorders result from alcohol's effects on metabolism and the GI tract. The disorders include:

a. Different types of anemias.

b. Poor clotting.

c. Decreased white blood cell (WBC) function.

6. Explain that the renal disorders result from alcohol's effects on hormones, causing the following disorders:

    a. Edema and hypertension.

    b. Acid base imbalance.

    c. Muscle weakness.

    d. Heart beat disturbances.

7. Explain that studies have shown an association between heavy alcohol consumption and cancer.

8. Explain that chronic alcohol abuse can predispose an individual to several types of disorders, such as:

    a. Diabetes.

    b. Hypoglycemic shock.

    c. Arteriosclerosis.

    d. Gout.

9. Explain that both psychological and physical dependence is common to chronic alcohol abuse.

EVALUATION

1. What are the three principle types of liver disorders resulting from chronic alcohol abuse?

2. What are three types of CNS disorders?

3. What are three types of GI tract disorders?

PRESENTATION

6e. CRITERION OBJECTIVE: Identify the primary symptoms of a typical alcohol withdrawal and the four critical stages, which may develop in cases of marked physical dependence.

1. Explain that tremors ("the shakes") is the first and most common stage. Typical withdrawal is associated with, and usually limited to, the following symptoms. In withdrawals involving marked dependence, these symptoms only represent the first stage of withdrawal.

a. Tremors.

b. Nausea, vomiting, and GI cramps.

c. Anxiety, insomnia, and depression.

d. Excessive sweating.

e. Muscle weakness and increased reflexes.

2. Describe hallucinations, which are accompanied by:

a. Restlessness and agitation.

b. Fitful sleep.

c. Mental clouding.

d. Fear.

3. Explain that convulsions ("rum fits") is one of the most dangerous stages. The symptoms include:

a. Total breakdown of CNS regulatory functions.

b. Generalized convulsions.

c. Short periods of unconsciousness, followed by disorientation.

4. Explain that delirium tremens (DTs) rarely occur. Symptoms characterizing this stage include:

a. Hallucinations and delusions.

b. Mental confusion and disorientation.

c. Agitation and convulsions.

d. Possible heart failure.

EVALUATION

1. What are the four critical stages, which can develop during the progressive sequence of alcohol withdrawal?

2. What stage of withdrawal is probably the most dangerous of the series?

APPLICATION

1. This hour's exercise consists of role-playing four hours of drinking so as to study the effects of alcohol on the participant's central nervous system. CAUTION: Ask if there are any recovered alcoholics in the group. Recovered

alcoholics should NOT participate in this exercise. Invite them to observe and report on the exercise. Ask the other group members to pair and begin fantasizing that they are drinking their favorite alcoholic beverage. They should describe their feelings to their partner as they progress. Explain what is happening to them as they move through the effects of increased amounts of alcohol.

a. HOUR ONE, which is completed during the first ten minutes, is conducted as follows: Explain the after one drink (one ounce of alcohol) conversations may be stilted, with very few participants, and general topics may be work-oriented. The first two drinks are slowly dispersed through the stomach, depending on the body metabolism of the drinker and his/her tolerance to alcohol. Beverages, such as beer and wine,

may take longer because of food value as opposed to whiskey or gin, which have a counter-food value and will get to the blood stream faster.

b. HOUR TWO, second ten minutes. Explain that after drinks two and three the conversation becomes more glib and skin more flushed. It becomes warmer in the room, and outer garments are removed. No distinguishable slur of words at this time, nor is there any lack of coordination; mostly a loosening of inhibitions.

c. HOUR THREE, third ten minutes. Explain that after drinks four, five, and six. They are drinking more now and tasting less. Speech is now affected, as well as visible coordination. Inhibitions are gone, and talk is loose. Long-term memory is now affected, and

most information shared stays in the short-term memory. Whole sentences are "chopped off," and no deep coversations are possible, except in extreme cases, as in arguments.

d. Hour four, final ten minutes. Explain that after drinks seven, eight, or more, the central nervous system is fully affected, as well as brain cells/functioning. Vision and coordination are impaired.

2. Discuss general alcohol pharmacology and the students' impressions during the experience.

CONCLUSION (10 Minutes)

SUMMARY

We have discussed the following:

a. Alcohol terms and characteristic actions.

b. Factors influencing alcohol's effects.

c. Acute, physiological effects of alcohol.

d. Chronic disorders of alcohol abuse.

e. Stages of the alcohol withdrawal sequence.

REMOTIVATION

The alcohol abuse problem in this country is increasing. Many individuals are turning to alcohol, with the mistaken belief that it is a "safe" and "acceptable" alternative to other drugs of abuse. Education in alcohol pharmacology can help to correct much of the misinformation about alcohol. This education is not going to stop alcohol use, but, hopefully, it may decrease alcohol abuse.

ASSIGNMENT

Give complementary technical training assignment, when appropriate.

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STUDY GUIDE/WORKBOOK

3ALR73430B/30LR7361B/30ZR7364B-II-5-9

Technical Training

DRUG AND ALCOHOL ABUSE CONTROL

ALCOHOL PHARAMACOLOGY.

March 1978

USAF TECHNICAL TRAINING SCHOOL
Lackland Air Force Base, Texas 78236

Designed for ATC Course Use

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Social Actions Training Branch
Lackland Air Force Base, Texas

SH 3ALR734308/30LR7361B/
30ZR7364B-II-5-9
20 March 1978

ALCOHOL PHARMACOLOGY

OBJECTIVE

Identify the physical and psychological effects of alcohol in humans.

INTRODUCTION

Alcohol is the most universal drug known to man. Its use extends from social drinking to alcoholism. Alcohol comes in different forms each equally effective. The form of alcohol used in merely a matter of taste, cost, and the need for effect. Alcohol itself is neither a "safe" nor a "dangerous" drug. Its benefit or deteriment is determined by the manner in which it's used. Alcohol abuse has reached epidemic proportions in this country. Partly because of its easy accessibility, limited legal implications, and general acceptibility of use in our society, alcohol is becoming a popular alternative to other drugs of abuse. A basic understanding of alcohol pharmacology is essential in dealing with the problems of alcohol abuse.

INFORMATION

ALCOHOL TERMS, CLASSIFICATION AND CHARACTERISTICS

Terminology

Alcohol is, by any definition, a drug. The term alcohol applies to an entire class of organic chemicals. It is used here to denote one particular organic alcohol, that being ethyl alcohol or ethanol. Certain organic alcohols can produce CNS depressant efforts similar to those of ethanol, however they differ widely in other phmacologic actions and many are not generally intended for human consumption, e.g. rubbing alcohol.

Classification and Characteristics

Pharamacologically, alcohol is classified as a CNS depressant, sedative-hypotic. Its range of effects on the CNS is very similar to other CNS depressants, i.e. barbiturates, nonbarbiturate sedative-hypotics, and even general anesthetics. Although alcohol has other physiological actions considerably different from these CNS depressant sedative-hypotics, it does share four characteristics with this class of drugs.

DEPENDENCE. As with the other CNS depressants, chronic use of alcohol can result in both psychological and physical dependence. Acquired dependence to alcohol involves a combination of the amount, the frequency and duration of use, and the personal make-up of the individual. Physical dependence to alcohol is characteristically coupled to the development of tolerance to the drug's actions.

TOLERANCE. Tolerance to alcohol requires that larger doses be taken to produce the same effects. It is the basis for physical dependence to alcohol, as well as to other drugs in the same class. As with the barbiturates, alcohol tolerance does not change the lethal dose; therefore, as the amount of alcohol is increased to produce a given effect, the chance of a lethal overdose also increases.

CROSS TOLERANCE. Just as tolerance develops to the effects to each CNS depressant, cross tolerance to the CNS actions of alcohol occurs between the various depressants, with the notable exception of the narcotics. Although one drug's effects can be substituted for another's, the combined use of two or more sedative-hypnotic depressants can increase the effects of each other, thus increasing the risk of toxicity. This cross tolerance property is used in treating alcohol withdrawal, whereby another sedative-hypotic is used to ease the alcoholic through his abstinence from alcohol.

WITHDRAWAL. Withdrawal, like tolerance, is closely associated with physical dependence. Withdrawal among the depressant agents is similar and can be stopped or lessened by substituting another sedative-hypnotic for the one discontinued. Barbiturate withdrawal is a serious matter and can be fatal. Alcohol withdrawal by comparison is only slightly less serious, whereas narcotic withdrawal is uncomfortable but seldom fatal.

Exercise VII-1

Complete the following exercise. The correct answers are provided in the Appendix.

1. What is the pharmacologic classification of alcohol?

2, What other types of drugs are included in the same class as alcohol?

3. What characteristics does alcohol share with the other types of drugs in its class?

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FACTORS INFLUENCING ALCOHOL EFFECTS

Dose-Time-Response Relationship

The effects of any drug, including alcohol, are dose and time dependent. To produce an effect, the drug must be present at its site of action at a sufficient concentration (base). The time course involved in getting the drug to and eliminating it from its site of action also determines the type and intensity of response. Pharmacodynamic processes such as absorption, distribution and metabolism are important to dose-time-response relationship. There are, in addition, contributing aspects, which influence these processes, thus affecting the overall response to alcohol.

Pharmacodynamics

ABSORPTION. The rate of absorption into the bloodstream determines the blood alcohol concentration (BAC) that is achieved. The BAC is measured as the number of milligrams per 100 millimeters of blood). Absorption is influenced by the rate of alcohol consumption, conditions in the stomach and gastrointestinal (GI) tract, and the type of drink.

Rate of Consumption. The rate of alcohol consumption determines the amount taken in. The amount of alcohol in an average drink is approximately 0.75 ounces. The table below shows that different forms of alcoholic beverages vary in the parcentage of alcohol per volume, as well as the total volume of liquid per drink. The quantity of alcohol per drink is approximately the same regardless of the form in which it is consumed.

Form	Strength	Volume	Quantity of Alcohol
Distilled Spirits	50%	1.5 oz	0.75 oz
Beer	4.5%	16 oz	0.72 oz
Wine	14%	5 oz	0.70 oz

Intake exceeding one drink per hour usually results in accumulation of alcohol and subsequent effects on the body. Up to a point, the larger the amount of alcohol present in the GI tract, the faster absorption.

Condition of GI Tract. Since about 20% of the alcohol is absorbed in the stomach and 80% is absorbed in the small intestines, the condition of the GI tract is important to the absorption process. Alcohol is absorbed faster when the stomach empty, whereas the precence of food reduces absorption. The rate at which the stomach empties its contents into the small intestines also effects absorption. Stomach empting time is influenced by the type and amount of food present, as well as mental factors such as anger, fear and stress.

Type of Drink. The form of alcohol beverage also influences alcohol absorption. Beer and wine are absorbed slower than distilled spirits, due to certain nonalcoholic substances contained in them. In addition, diluting

alcohol with another liquid, such as water, slows absorption. Mixing alcohol with carbonated beverages however, increases absorption.

DISTRIBUTION. Once the alcohol is absorbed into the bloodstream, it must be distributed to its site of action in order to produce an effect. Since alcohol is evenly distributed throughout the body, the size and weight of an individual determines the volume in which the alcohol is to be distributed.

Size and Weight. The size and weight of an individual determines the body volume in which alcohol is distributed. For a given amount of alcohol, the larger the volume of distribution, the smaller the alcohol concentration at a particular site in the body. Therefore, the same amount of alcohol has a greater effect on a smaller person than on a larger person.

METABOLISM. The effects of alcohol are terminated by the liver, where alcohol is metabolized (oxidized). About 90% of the alcohol in the body is oxidized in the liver by the series of reactions shown in the figure below. The end products of alcohol metabolism are energy, CO_2, H_2O, and Calories (200 calories per ounce of alcohol).

Alcohol --> Acetaldehyde --> Acetate --> Energy + CO_2 + H_2O + Calories

In addition, only about 10% of the alcohol is excreted from the body, unchanged by metabolism, through respiration, urine, tears, saliva, sweat and other lesser means. Alcohol is metabolized at a fairly constant rate. In a 150 lb. person, alcohol is oxidized at a rate of 0.75 ounces (one drink) per hour. When alcohol consumption exceeds the limits of the metabolic processes, alcohol accumulates and the effects of alcohol on the body increase.

Enzyme Stimulation. Certain drugs, including the barbiturates, other sedative-hypnotics and even alcohol itself, can stimulate the activity of liver enzymes involved in metabolizing alcohol. This increase in enzyme activity results in a faster rate of alcohol metabolism, thus a shorter duration of effect. This enzyme stimulation is of limited capacity however.

Exercise VII-2

Complete the following exercise. The correct answers are provided in the Appendix.

1. What are the three pharmcodynamic processes influencing the dose-time-response relationship?

2. How does the rate of alcohol consumption influence the overall response to alcohol?

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ACUTE EFFECTS OF ALCOHOL

Behavioral - Performance

The short term (acute) depressant effects of alcohol on the CNS are responsible for a wide range of behavioral-performance responses. These responses are dose-time dependent with regards to type and intensity of effect. This dose-time dependence of the response is under the influence of various factors.

GRADED DOSE RESPONSE. The table below shows the relationship between the amount of alcohol (drinks) consumed per hour, the blood alcohol concentration (BAC), and the behavioral-performance response produced. The data presented in the table relates to a 150 lb. individual who metabolizes 3/4 to 1 ounce of alcohol per hour. The quantity of alcohol per drink corresponds to the table of information presented on page 3. This correlation of data below is not exact and individual variations will occur in the general population.

DRINKS PER HOUR	BAC (mg%)	RESPONSES
2	0.05	Relaxation; disinhibition; recent memory loss; talkativeness; reduced reflexes.
4	0.10	Motor skills impaired; speech slurred; judgement impaired; quarrelsomeness; legal intoxication (some states 0.15 mg%).
8	0.20	Depression of entire motor area; emotional instability; inattentiveness; uncoordinated gait.
12	0.30	Confusion; stupor; poor comprehension; depression of respiratory-cordiovascular functions.
18+	0.50+	Coma; respiratory-cardiovascular arrest; death.

The type and intensity of the responses are dose-time related and correspond with the progressive depression of different brain sturctures. This progression of effects is not unique to alcohol. It can be produced by many other CNS depressant drugs, such as barbiturates, nonbarbiturate sedative-hypnotics, and general anesthetics.

Physiological

While the behavioral-performance effects of short term alcohol use result from the drugs depressant action on the CNS, the physiological effects of alcohol involve the entire body. These effects are due to either direct or indirect actions of alcohol on various systems in the body. Many of these effects

are interrelated with others. The basis for most of these effects are either unknown, ill defined or controversial. The effects are, of course, dose-time dependent and influenced by different factors. The effects may be grouped according to the general body function affected. The basic physiological effects of alcohol of importance are as follows:

METABOLISM. Alcohol can cause changes in the production, breakdown and storage of fats, sugars and protein, at the cell level, in different organs. The most notable organs affected are liver, heart, and muscle. The main effects produced by these changes include:

1. Increased blood sugar, or

2. Decreased blood sugar.

3. Increased blood fat.

4. Fat accumulation in organs (liver, heart, muscle).

GASTRO-INTESTINAL (GI) TRACT. GI tract consists of the stomach, intestines, pancreas and to a certain extent, the liver. Alcohol effects here include:

1. Increased release of stomach acid juice.

2. Irritation of the GI tract lining.

3. Interference with the absorption of vitamins and nutrients (vitamins B, C, and K; folic acid, amino acids and others).

ENDOCRINE SYSTEM. The endocrine (hormone) system involves many different hormones, each acting on the body to produce a particular effect. Alcohol can change the actions of these harmones and thus their effects, by interfering with their release, production or breakdown. The principle effects caused by these changes include:

1. Changes in the metabolism of fats, sugars and proteins.

2. Increased urine flow (diuresis).

3. Potassium loss.

BLOOD. Blood is affected primarily through the effects of alcohol on other organs. These indirect effects include decreased GI tract absorption of vitamins and nutrients and increased blood levels of fat. These actions result in the following effects on blood:

1. Poor clotting.

2. Decreased functioning of blood cells.

RENAL SYSTEM. The effect on the renal (kidney) system results primarily from alcohol's action on metabolism and hormones. The effects seen on the kidney include:

1. Increased urine flow (diuresis).

2. Electrolyte (salts and minerals) loss.

TEMPERATURE CONTROL. The action of alcohol on temperature control of the body is directed mainly on blood vessels close to the surface of the skin. This action expands the vessels, increasing blood flow to the skin's surface, causing decreased body temperature by increasing heat loss.

Exercise VII-3

Complete the following exercise. The correct answers are provided in the Appendix.

1. What do the acute effects of alcohol on behavior-performance result from?

2. What is the difference in alcohol's site of action in producing behavior-performance as apposed to its physiological effects?

3. What are the six basic types of physiological effects of alcohol?

CHRONIC DISORDERS

Pathology

The pathology (diseases) of chronic alcohol abuse is extensive. The type and degree of disorder depends on the duration of abuse and the individual's biological make-up. In most instances, the cause of the disorder is either unknown or controversial and the role of alcohol is not totally clear. In other cases, the disorder is a direct consequence resulting from one or more of the basic physiological effects of alcohol on the body.

LIVER. Progressive liver damage is common to alcohol abuse. The damage is associated with changes in liver metabolism and nutritional deficiencies due to poor absorption in the GI tract. Liver disorders occur in series as follows:

Fatty Liver. This primary change results from the favored metabolism (oxidation) of alcohol in place of sugars and fats. Fat accumulates in cells causing

enlargement and decreased metabolic capabilities of the liver. At this stage, damage is repairable if accohol use is stopped. Further abuse advances the disease process.

Alcoholic Hepatitis. Hepatitis is an inflammation of the liver characterized by:

1. Juandice (yellowing of the skin).
2. Decreased liver function.
3. Increased toxic ammonia in blood.
4. Swelling of the liver.

This condition can lead to total liver failure followed by coma and death. If alcohol use is stopped, the liver will repair itself; a totally damaged liver can repair itself in about 6-8 weeks.

Cirrhosis. Liver cirrhosis (scarring of the liver) is the final stage of liver damage. The degree of cirrhosis can vary causing partial to complete liver failure. It is not reversible and results in permanent decreased function.

CNS. CNS disorder are common and often associated with metabolic changes and nutritional deficiencies due to poor absorption. These effects of alcohol result in disorders involving nerves as well as the brain.

Alcoholic Neuropathy. This disease of the nerves is often associated with myopathy (disease of muscles). Deficiency of B Vitamins affects the nerve's control of muscle. In muscles, metabolic changes causing fat accumulation and tissue destruction affect muscle functions. This includes the heart and its function. The symptoms of nerve-muscle disorders include muscle weakness, pain, and paralysis. The effects are reversible to varying degrees, with proper treatment.

Wernike's Encephalopathy. This brain disorder involves impaired mental processes and inability to control muscles. It results from a vitamin B deficiency and is reversible to some extent by treatment with B vitamins.

Jolliffe's Encephalopathy. This brain disorder is similar to Wernike's and results from niacin (a B vitamin) deficiency. Treatment with niacin reverses some symptoms.

Korsakoff's Psychosis. Severe mental malfunction and brain damage make up this CNS disorder. Nutritional deficiencies and metabolic changes are indicated as underlying causes. The disease is not reversible and there is no specific therapy.

Marchiafava's Disease. This disorder is similar to Korsakoff's. It is not reversible and there is no specific treatment. Diagnosis is usually determined by autopsy.

GI TRACT. There are numerous disorders of the GI tract attributed to the chronic effects of alcohol. The irritation to the GI tract lining and increased stomach acid release caused by alcohol result in disorders such as:

1. Ulceration and scarring of the tract lining.

2. GI tract bleeding.

3. Inflammation of the stomach.

4. Inflammation of the pancreas.

5. Poor absorption.

BLOOD. The chronic effects of alcohol on metabolism and the GI tract indirectly result in several blood disorders. These alcohol effects involve metabolic impairment of liver function and malabsorption of nutrients by the digestive tract. The blood disorders include:

1. Different types of anemias.

2. Poor clotting.

3. Decreased white blood cell function, thus lowered resistance to infection.

4. Sludging of red blood cells.

RENAL. Renal (kidney) disorders result primarily from alcohol's long term effects on hormones, which in turn affects renal function. Hormone actions on salt, water, and waste excretion by the kidney, can result in the following disorders"

1. Edema and hypertension resulting from salt and water retention.

2. Acid-base imbalance due to electrolyte loss.

3. Muscle weakness caused by potassium loss.

4. Heart beat disturbances also due to potassium loss.

CANCER. Studies show an association between heavy alcohol consumption and cancer of the respiratory and GI tracts and the liver. This association is not clear-cut. Exactly how alcohol is related to carcinogenesis (cancer formation) is not known. Some possibilities include:

1. Alcohol action by a single or combination of physiological effects.

2. Alcohol acting together with another agent (chemical or viral).

3. Nonalcoholic substances in alcoholic beverages may be cancer producing.

PREDISPOSITION. Chronic changes in metabolism caused by alcohol, can potentially predispose an individual to several additional disorders. These disorders and their causes include:

1. Diabetes, due to increased blood sugar.

2. Hypoglycemic shock, resulting from an extreme decrease in blood sugar.

3. Arteriosclerosis may be enhanced by increased blood fats.

4. Gout can be caused by increased uric acid in the blood.

5. Fetal - Alcohol Syndrome

DEPENDENCE. Both psychological and physical dependence are common results of long term alcohol abuse. Tolerance and withdrawal are part of the dependence state and have been discussed previously.

Exercise VII-4

Complete the following exercise. The correct answers are provided in the Appendix.

1. How do the basic physiological effects of alcohol relate to the chronic disorders of alcohol abuse?

2. What are the three physiological effects interrelated with the chronic disorders of alcohol?

3. What chronic disorders are attributed to the effects of alcohol on the GI tract?

ALCOHOL WITHDRAWAL

Symptoms

All drugs producing physical dependence show withdrawal when the drug is stopped. Alcohol withdrawal symptoms do not appear until the blood alcohol level drops below some "critical" intoxication level; usually occurring three hours after the last drink. The severity of withdrawal symptoms depends on the amount of tolerance which had been established to the drug. Withdrawal from

alcohol, like that from barbiturates is a serious, medical emergency, which can be fatal. Alcohol withdrawal follows a series of well defined stages, starting with tremors ("the shakes") progressing through alcoholic hallucinosis, and possible going as far as delirium tremens (DTs). This progressive sequence of symptoms will vary according to the amount of tolerance. It can be stopped at any point by substituting almost any sedative-hypnotic, CNS depressant, using the cross tolerance property occuring within this class of drugs.

TREMORS. This is the first and most common stage in the withdrawal sequence. A typical alcohol withdrawal is indicated by the tremor stage and the symptoms exhibited in this stage. It is associated with such symptoms as:

1. Tremors ("the shakes").
2. Nausea, vomiting and GI cramps.
3. Anxiety, insomnia, and depression.
4. Excessive sweating.
5. Muscle weakness and increased reflex actions.

HALLUCINATIONS. Alcoholic hallucinosis follows and can last several days, with increasing intensity. Auditory (hearing) hallucinations usually predominate. Other symptoms at this stage include:

1. Restlessness and agitation.
2. Fitful sleep.
3. Mental clouding.
4. Fear.

CONVULSION. This stage of "rum fits" is probably the most dangerous in the series. These symptoms can indicate the onset of DTs, and include:

1. Total breakdown of CNS regulatory functions.
2. Generalize (Grand Mal) convulsions.
3. Short periods of unconsciousness followed by disorientation.

DELIRIUM TREMENS. Rarely will withdrawl from alcohol progress to the stage of DTs. About 10-15% of the cases die at this stage if no medical treatment is given. The symptoms characterizing DTs include:

1. Terrifying hallucinations and delusions.
2. Intense mental confusion and disorientation.

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3. Agitation and convulsions.

4. Possible heart failure.

Exercise VII-5

Complete the following exercise. The correct answers are provided in the Appendix.

1. What types of drugs show withdrawal following their discontinued use?

2. What determines the intensity and extent of the withdrawal symptoms?

3. What are the four critical stages, which can develop during the progressive sequence of alcohol withdrawal?

4. What types of drugs can be used to stop alcohol withdrawal symptoms and what is the property on which their use is based?

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APPENDIX

ANSWERES TO EXERCISES

Exercise VII-1

1. CNS depressant, sedative-hypnotic.

2. a. Barbiturates

   b. Non-barbiturate sedative-hypnotics.

   c. General anesthetics.

   d. Narcotics.

3. a. Depress CNS functions.

   b. Psychological and physical dependence.

   c. Tolerance

   d. Cross tolerance.

   e. Withdrawal syndrome.

Exercise VII-2

1. a. Absorption.

   b. Distribution.

   c. Metabolism.

2. Determines the amount (dose) taken in. The larger the amount, the faster the absorption. A consumption rate greater than one drink per hour exceeds metabolic capacity so alcohol accumulates and its effects on the body increase.

Exercise VII-3

1. Dose-time related, progressive depressant effects of alcohol on different brain structures.

2. The site of action of alcohol's behavioral-performance effects is the CNS, whereas the physiological effects result from alcohol acting on various body organs.

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3. a. Metabolism.

   b. GI tract.

   c. Endocrine system.

   d. Blood.

   e. Renal system

   f. Temperature control.

Exercise VII-4

1. Many basic physiological effects of alcohol over a long term can provide an underlying basis for the development of certain disease states.

2. The primary physiological effects involved have to do with alcohol actions on metabolism, GI tract, and harmones.

3. a. Ulceration and Scarring.

   b. GI tract bleeding.

   c. Gastriris. Inflammation of the stomach.

   d. Pancratitis. Inflammation of the pancreas.

   e. Poor absorption.

Exercise VII-5

1. All drugs producing physical dependence.

2. The degree of tolerance developed to the drug.

3. a. Tremors.

   b. Hallucinations.

   c. convulsions.

   d. Delirium tremens.

4. a. Any sedative-hypnotic, CNS depressant.

   b. cross-tolerance.

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Social Actions Training Branch
Lackland Air Force Base, Texas

Q 3ALR73430B/30LR7361B/30ZR7364B-II-5-32
20 March 1978

Score_____%

ALCOHOL PHARMACOLOGY QUIZ

Rank_____ Name _____ Group_____
Last First MI

Circle Correct Answer

C.O. #

5a. 1. The effects of alcohol are most like:

a. Nicotine

b. Barbiturates

c. Cocaine

d. Marijuana

2. Alcohol effects are:

a. Dose related

b. Time related

c. Influenced by pharmacodynamic processes

d. All of the above

3. The physiological effects resulting from short-term alcohol use are:

a. Inter-related

b. Dose-time dependent

c. Involved the entire body

d. All of the above

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Do Not Use on the Job.

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4. The type and degree of systemic disorder resulting from chronis alcohol abuse primarily depends on:

   a. Withdrawal

   b. Fatty liver

   c. Duration of abuse

   d. Korsakoff's psychosis

5. Typical alcohol withdrawal is usually limited to the following symptoms, except for:

   a. Tremors

   b. GI cramping

   c. Muscle weakness

   d. Generalized convulsions

MODIFICATIONS

Section 5 of this publication has (have) been deleted in adapting this material for use in Vocational and Technical Education. Deleted material involves extensive use of military forms, procedures, systems, etc. and was not considered appropriate for use in vocational and technical education.

NOTE: PAGE 958 HAS BEEN DELETED.

PLAN OF INSTRUCTION/LESSON PLAN PART I

NAME OF INSTRUCTOR	COURSE TITLE
	Drug and Alcohol Abuse Control 959
BLOCK NUMBER: II	BLOCK TITLE: Basic Skills and Knowledges

1 COURSE CONTENT	2 TIME
6. Etiology and Progressive Characteristics of Alcoholism a. Identify the physical and psychological characteristics that accompany the development of alcoholism. SUPPORT MATERIALS AND GUIDANCE Student Instructional Materials SW B-II-7-12, Etiology and Progressive Characteristics of Alcoholism HO B-II-7-15, Alcoholism Roles Worksheet Audio-Visual Aids 16mm Film, "The Summer I Moved to Elm Street" (SFP 1968, 30 min) 35mm Slides, "Etiology of Alcohol Abuse" 16mm Film, "Chalk Talk on Prevention" (AFIF 322, 45 min) Training Methods Lecture Discussion Instructional Guidance Define alcoholism and discuss the issue of disease versus illness, versus dependency. Identify the major physiological, psychological, and sociological theories on the causes of alcoholism. Trace the development of increasing dependency on alcohol. Provide insight into alcoholism as experienced in the family and what is known about female alcoholics. In small groups, provide practical exercises to reinforce lesson objectives.	

SUPERVISOR APPROVAL OF LESSON PLAN (PART II)

SIGNATURE AND DATE	SIGNATURE AND DATE

PLAN OF INSTRUCTION NUMBER	DATE	PAGE NO.
L3ALR73430B/L30LR7361B/L30ZR7364B	30 May 1978	25

ATC FORM OCT 78 133 PREVIOUS EDITION IS OBSOLETE

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STUDYGUIDE WORKBOOK

SW 3ALR73430B-30LR7361B-30ZR7364B-II-T-12

Technical Training

Drug and Alcohol Abuse Control

Basic Skills and Knowledge

ETIOLOGY AND PROGRESSIVE CHARACTERISTICS OF ALCOHOLISM

1 June 1978

HEADQUARTERS 3250 TECHNICAL TRAINING WING (ATC)
USAF Technical Training School
Lackland Air Force Base, Texas 78236

DESIGNED FOR ATC COURSE USE. DO NOT USE ON THE JOB.

ATC FORM 214 (JAN 78) OBSOLETES ATC FORMS 214, MAY 69, 522, NOV 63 AND 523, MAY 71. STANDARD COVERSHEET

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Social Actions Training Branch
Lackland Air Force Base, Texas

SW 3ALR73430B/30LR7361B/
30ZR7364B-II-6-1
1 June 1978

ETIOLOGY AND PROGRESSIVE CHARACTERISTICS OF ALCOHOLISM

OBJECTIVE

Identify the physical and psychological characteristics that accompany the development of alcoholism.

INTRODUCTION

After completing the study guide/workbook, you will be able to define alcoholism, to identify the physiological, psychological, and cultural theories about the causes of alcoholism, and to identify the progressive stages of alcoholism. This information will help prepare you for your role as an educator and a rehabilitation program counselor.

INFORMATION

DEFINITIONS OF ALCOHOLISM

The Illness Concept

The American Medical Association defines alcoholism as "an illness characterized by preoccupation with alcohol and the loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity; by progression. . . .It is typically associated with physical disability and impaired emotional, occupational, and/or social adjustments. . . ."

Defining alcoholism as an illness implies that its treatment is primarily a medical matter and that patient relapse should not be considered abnormal. The goal of treatment is viewed more as a question of control than of cure, as with diabetes. Chronicity infers a need for long-term treatment, and progression indicates that if alcoholism goes untreated, it worsens rather than improves.

The Disease Concept

Dr Mark Keller defines alcoholism as "a chronic disease manifested by repeated implicative (suspicion-arousing) (parentheses provided) drinking so as to cause injury to the drinker's health or to his social or economic functioning".

This approach to alcoholism helps remove the stigma attached to it and lessens the guilt carried by the alcoholic, by freeing him/her from the personal responsibility for having it. Alcoholism, like any other disease, is contracted from an external source. It is not the result of moral deficiencies nor a lack of willpower.

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The Uncontrolled Drinking Concept

Northwestern Bell Telephone defines alcoholism as "problem drinking. . ." and a "chronic, uncontrolled drinking pattern which impairs the ability of the individual to live and work in a normal and acceptable manner. . . .The quantity of alcohol consumed is not necessarily the consumption of any amount, nor his actions under its influence."

Here, alcoholism and problem drinking are viewed as being synonymous (one and the same), only because of the end result. Both impair the worker's performance significantly, and therefore, are matters for equal concern and immediate action. The primary goal is to treat the worker, not to waste valuable time arguing whether he/she is an alcoholic or a problem drinker. That exercise is left to the physician.

The Dependency Concept

Air Force defines alcoholism as a psychological or physical dependence on alcohol and establishes three levels of involvement: Occassional excessive drinking, habitual excessive drinking, and addiction. The degree to which the individual's preoccupation with alcohol dominates his/her life style determines the level.

Air Force, like industry, is not primarily concerned with whether a member is alcoholic or a problem drinker; but, rather, that all members, whose work performance is deteriorating because of drinking, receive immediate assistance as early as possible, in order to prevent further, deepening involvement.

ETIOLOGY OF ALCOHOLISM

Etiology refers to the cause or causes of a condition. A theory is a general principle drawn from a body of facts, as in a science. Theories about the etiology of alcoholism are summarized generalizations based upon many facts about, and observations of, people with this condition.

Physiological Theories (biochemical and Physical Disorder)

GENETOTROPHIC THEORY. The position of this theory is that an inherited, nutritional vitamin deficiency, essentially the B-Complex, causes an excessive craving or perference for alcohol in the individual.

Credibility. Alcoholics, as a group, tend to be deficient in certain vitamins, especially Vitamin K and the B-Complex Vitamins. However, it is not known whether or not these deficiencies existed prior to the alcoholism. It is known, however, that vitamins are not stored by the human body and that their absorption is suppressed in the presence of alcohol; therefore , these deficiencies would be expected. The question then becomes, "Do vitamin deficiencies cause alcoholism, or does alcoholism cause the vitamin deficiencies?" Prehaps the fact that nonalcoholic persons who are deficient in Vitamins K and B do not predictably become alcoholic helps resolve this question.

GENETIC THEORY. The basic position of this theory is that a susceptability toward alcoholism is inherited and runs in families.

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Credibility. Studies involving similar blood groups, color blindness, identical twins, and offsprings of alcoholic parents in foster homes have proved uninformative. However, the use of alcohol in the family has a definite influence on the children, and alcoholism does run in families.

ENDOCRINE THEORY. The basic position of this theory is that alcoholism is caused by a dysfunction of the endocrine (hormone-producing glands) system.

Credibility. As with nutritional deficiencies, endocrine dysfunction seems to be a result of rather than a cause of alcoholism.

Psychological Theories (Symptom of Underlying Personality or Emotional Disorder).

PSYCHOANALYTIC THEORY (FREUDIAN VIEW). Alcohol releases the inhibitations, allowing the expression of repressed (unacceptable and unconscious) urges. Alcoholism results from a person's overwhelming need to express these urges.

Oral Dependence. Oral fixation produced by a lack of demonstrated parental affection during infancy. The individual seeks love, nurture, and security. Alcohol fulfills this need.

Latent Homosexuality. Lack of affection from the over-aggressive, dominant mother results in an over-identification with first the father and then other males. Drinking and camaraderie provide a socially-acceptable way to associate with men and gain their affection.

Self-Destructive Tendency. Guilt is associated with feelings of hostility toward the parents for not meeting the need for oral gratification. Alcohol satisfies the oral craving, then becomes a form of self-punishment for the anger toward parents. Alcoholism symbolizes revenge against the parents.

PSYCHOANALYTIC THEORY (ADLERIAN). Overindulgent parents prevent the child's learning to cope with life problems, resulting in feelings of inferiority and low self-esteem. Alcohol compensates for these feelings by blostering feeling of power and worth.

CREDIBILITY. Evidence to support the psychoanalytic views is inconclusive. Alcoholics are often found to have strong, unfufilled needs; however, it is not known whether these needs existed prior to alcoholism. Additionally, it is not known whether the success reported by psychoanalysts is from the therapy or the long-term personal attention by the therapist.

LEARNING THEORY. Drinking is selected as a repeated behavior through positive, uncounscious conditioning or reinforcement. The individual learns that alcohol releives the anxiety associated with life problems or the need to cope with reality. However, the more it is used as a coping mechanism, the more anxiety-producing reality becomes, because of the lack of effective coping. This ultimately leads to the need for alcohol as a defense against an everworsening reality. Alcohol is most closely associated with the release from anxiety rather than the cause. This is due to the immediacy of the

positive reinforcement, which is basic to learning theory. Learning theorists believe alcoholism is a habit of using alcohol to reduce anxiety.

Credibility. The application of the learning theory in the treatment of alcoholism has met with varying degrees of success in aversion therapy and behavior modification programs.

TRANSACTIONAL THEORY. Alcoholism is the result of an early decision made by the individual, rather than being a disease or being caused by an emotional distrubance. This decision, made in the person's childhood, establishes a life script (the onset), brought about by the person's acceptance of a "don't be," "don't-succeed"or a "don't-be-close" injunction. This script has its "course" during the person's adult years, when the struggle is waged against the script, alcoholism, a form of self-destruction, being one way such scripts are lived out. The "outcome" occurs when and if the individual succumbs to alcoholism.

Credibility. The transactional approach to alcoholism is relatively new, and unsufficient data have been collected to determine its validity. However, the general portrayal of the individual's involvement with alcoholism appears to be sound. But it is not a broad enough theory to account for all facts concerning alcoholism.

PERSONALITY THEORY. Alcoholics possess certain common personality traits indicating a predisposition toward alcoholism. They collectively demonstrate a low frustration tolerance, inadequate defense mechanisms against need-gratification, a pronounced dependency upon others, and unresolved love-hate ambivalences.

Credibility. The validity of this theory is questionable. The persons in the study groups are already alcoholic, and any predesposition they may have had prior to their alcoholism is unknown. Additionally, persons possessing all of the common personality traits identified do not predictably become alcoholic. For example, research indicates that many alcoholics, although not all alcoholics, have dependent personalities; however, it is not known whether their dependency existed prior to the onset of alcoholism or as a result of it.

Socio-Cultural Theory (Product of the Social and Cultural Environment).

BASIC POSITION. A.D. Ullman best summed up this view in article, "Socio-cultural Backgrounds of Alcoholism." He stated, ". . .in any group or society in which the drinking customs, values, and sanctions -- together with the attitudes of all segments of the group or Society -- are well established, known to and agreed upon by all, and are consistent with the rest of the culture, the rate of alcoholism will be low. . . ." On the other hand, where ". . .the individual does not know what is expected or when the expectation in one situation differs from that in another, it can be assumed that he will have ambivalent (conflicting) (parentheses added) feelings about drinking."

INFLUENCING SOCIO-CULTURAL FACTORS. Socio-cultural theories identify seven factors operating in our society that influence an individual toward alcoholism.

Cultural Ambivalence. Social attitudes toward the use of alcohol are conflicting. Therefore, no agreed-upon standards have been established as to when, where, and how one should drink.

Lack of Cultural Integration. Drinking is predominantly viewed as an end in itself, rather than being thought of as an integral part of our culture associated, for example, with dietary practices as with the Italians or with religious rites as associated with the Jews.

Peer-Group Pressure. Acceptance and belonging are important to almost everyone. Individuals tend to modify their behavior to conform to the practices of the group(s) with which they are genuinely associated. If a group frequently encourages indiscriminate drinking, then most of its members usually conform to preserve their memberships.

Family Group. Drinking practices within the primary group (the family) greatly influence the individual's drinking practices through example, opportunity, and availability.

Sanctions. Society and the groups within it have very few well-defined, equally-applied sanctions (penalties) against excessive drinking and intoxication. Their position is unclear. In some groups, heavy drinking is viewed as a symbol of strength and manhood. Intoxication is expected and the accepted reason for drinking. While society, on the one hand, officially condemn excessive drinking and intoxication through its laws against drunkenness and driving while intoxicated (DWI), it indirectly condones these practices by failing to discourage them with consistency; for example, on special occassions such as reunions, wedding receptions, New Year's Eve celebrations, etc. Without positive, consistently applied sanctions against these practices, the rate of alcoholism goes unaffected.

Encouragement. Cocktail parties, happy hours, and advertising showing drinks before dinner, wine with dinner, and cordials after dinner all influence the individual's choice of how to spend his/her leisure hours. The pressure caused by the ever-quickening pace of society and its apparent emphasis on profits and production, rather than the well-being of the individual, also serve to make frequent drinking a psychologically rewarding practice for many.

Alternatives. Alternative pursuits to drinking are not encouraged by our society. Their mere presence and availibility are not sufficient, in light of the current lack of involvement of our citizentry. The introduction of alternatives should begin in the home with the family, as an integral part of the rearing process. Society's role then becomes one of reinforcement, rather than education and selling an idea.

CULTURE AND SOCIAL ORGANIZATION. Another supporter of the socio-cultural theory, R. F. Bales, identified three general ways in which culture and social organization influence rates of alcoholism, in his article entitled, "Cultural Differences in Rates of Alcoholism": (1) "The degree to which culture operates to bring about acute needs for adjustment, or inner tensions, in its members"; (2) "The sort of attitudes toward drinking which the culture produces in its members"; and (3) "The degree to which the culture provides suitable substitute means of satisfaction." He went on to cite three prominent cultural

attitudes toward drinking which influence varying rates of alcoholism in our societies today": (1) The Ritual attitude (Jews), where drinking is integrated into the religious rites and where social drinking is limited; (2) The Convivial attitude (United States), where drinking is often tied to a "ceremonial core" (a marriage) but also done socially, quite frequently; and (3) the Utilitarian attitude (Irish), where drinking is individualistic (self-centered) and no societal sanctions against it are active or enforced. Bales concluded that societies which hold the Ritual attitude toward drinking enjoy a low rate of alcoholism; that those holding the Convivial attitude show less societal concern about drinking and a correspondingly greater rate of alcoholism; and, finally, that societies or groups which express a Utilitarian attitude toward drinking record the highest rate of alcoholism.

CREDIBILITY. Neither culture nor society can be specifically identified as a sole cause of alcoholism; however, most experts in the field agree that their influence on the individual is considerable, through attitudes, family, and peer-group exposure, a lack of well-defined sanctions against excessive drinking, and the almost total absence of emphasis on alternative pursuits.

PROGRESSIVE CHARACTERISTICS OF ALCOHOLISM

INTRODUCTION

In this portion of the SW, we will trace the development of alcoholism in the individual. Three things should be remembered throughout: (1) all sufferers to not necessarily reflect all of the characteristics/behaviors described; (2) the characteristics/behaviors described do not necessarily occur in an exact order; and (3) the progression of alcoholism may take anywhere from two to twenty-five years, depending upon the person and the circumstances. The progression that follows examines the major stages in the development of alcoholism. The specific characteristics and behaviors that comprise each of the stages paint a composite picture of the "typical" alcoholic person in that particular stage. Caution should be exercised, however, whenever trying to apply any of these stage representations to a specific person in a specific set of circumstances.

Pre-Alcoholic Stage

The pre-alcoholic stage can begin at any time in life. It is characterized by increasing quantities of alcohol consumed, an increasing frequency of drinking episodes, occasional intoxication, and hangover. Overall, there is an absence of any identifiable pattern of drinker or set of drinker traits. Drinking habits tend to conform to those of the peer group. It is important to note that nonalcoholics can (and sometimes do) drink as much as pre-alcoholics, so that the two are not distinguishable, one from the other. For the pre-alcoholic, however, drinking takes on a special significance which may or may not be consciously recognized. The pre-alcoholic (1) finds that he/she appears to be able to drink more than other people without any noticeable difficulties or disapprovals; and (2) begins, only unconsciously, to look forward to (the origin of psychological dependence) drinking as an integral and important element in his/her life.

There is no time limit on how long people stay in the pre-alcoholic stage. Some remain there throughout their lives. Those progressing into alcoholism, however, move into the next stage unknowingly, taking with them some of the defense mechanisms of denial and rationalization on which they will eventually come to depend.

Characteristics of the Early Stage

The alcoholic normally enters this stage at the age of 25-27 and has several years on the job. He/she has unconsciously learned that alcohol is pleasant, and relieves anxiety. Its viability has been tested and proven in many varied situations. Its effects are quick, predictable, and guaranteed. This stage sees the alcoholic using alcohol primarily as a temporary release from situational or problem anxiety. It does nothing to improve the situation or to solve the problem; but, it is one hundred percent effective in releiving the alcoholic's concern over either.

GULPING AND SNEAKING DRINKS. The alcoholic feels more confident and comfortable (psychologically) when assisted by alcohol and so hastens to gain its influence. The sneaking of drinks is to preserve the acquired feeling state and to conceal the abnormal amount being consumed.

DAMAGED CONTROL (KEY STAGE CHARACTERISTIC). At this point, the alcoholic is no longer able to consistently choose how much or how long he/she will drink. When drinking is begun, it usually leads to intoxication. His/her ability to decide when to drink is still uneffected. NOTE: Most periodic (Episodic) drinkers are in this state. They may drink only once weekly or twice monthly, etc.; but, when drinking is begun, intoxication consistently follows.

BLACKOUTS. Approximately ninety-five percent of all recovered alcoholics interviewed reported having blackouts during the early stage. The blackout is often confused with the state of unconsciousness. In an alcoholic blackout, the individual walks, talks, and functions just like everyone else; but, later, has only a partial or no recollection of his/her actions.

HANGOVERS. These are mostly physical in nature, but now include some psychic pain (embarrassment and/or remorse). The alcoholic is experiencing guilt over the amount of alcohol he/she is consuming, the embarrassments associated with the comments of friends of family, and blackouts, if occuring.

NOTE: Many of your clients will be classified as early-stage alcoholics. Treatment and prognosis is very favorable.

Characteristics of the Middle Stage

In this stage, the alcoholic is normally in his/her early-twenties. Existing work habits, performance, and behavior differ from pre-established patterns. Indications of a problem or problems are becoming more apparent to supervisors and co-workers. For the alcoholic, substance tolerance is increasing. Drinking is now a defense against, as well as a release from, stress and anxiety (the vicious circle). Rationalization keeps the individual from facing the reality of his/her increasing dependence on alcohol.

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ALIBI SYSTEM. By this time, the alcoholic has developed a very elaborate system for camouflaging his/her drinking and its effects. In the morning, the tardiness, the "red eyes," the swelling in the face, the worn-out look, etc., are because of the flu or a cold that is coming or going, or because of being up all night with the baby or the spouse. Absences from the duty location during the duty day become increasingly more frequent, especially among persons who are able to manage their own schedules. These absences are explained as required meetings, coordination sessions (formal or informal), personal errands, additional duties, etc. At the close of the duty day, excuses such as "beat the traffic," "pick up the wife," "drop the car off at the shop," etc., are effective. The alcoholic often becomes the person who is there, but isn't there. Everyone has seen him/her (intentional), except the supervisor (planned avoidance). No one knows where he/she is at any given moment; but, most have seen him/her at one time or another and so can attest to his/her presence for duty. The key question for a work superbecomes, "Are the pattern of behavior and/or work performance different from those previously established?" If the answer is, "Yes," there is most probably something wrong. Use caution, however, because alcoholism is not necessarily the problem. By actual statistics compiled in industry, only about fifty percent of the cases which look like a alcoholism turn out to be alcoholism. Marital difficulties, for example, produce symptoms on the job which are very similar.

CHANGING DRINKING PATTERN. It occurs for different reasons or not at all. The specific reason for the shift determines the course it follows. For example, an increasing tolerance to alcohol may cause a shift from beer to wine to distilled spirits -- less bolume with greater effects in less time. As a side-benefit, it is easier to conceal (less bulk). A weakening alibe system may cause a shift in the preplanned schedule of daily drinking episodes. The presence of co-worker on a regular basis, if convenient, in order to establish an uncontestable nonalcoholic drinking pattern. To dispel a myth at this point, alcoholics often shift to vodka, not because it has no odor, but because it is concentrated, cheap, and looks like water.

RATIONALIZATION. Not to rationalize would mean that the alcoholic would have to admit his/her alcoholism, at least to self. But the alcoholic has the same opinion of "alcoholics" (stereotype) as most other people. He/she views them as weak, dirty, and disgusting. Rationalization, therefore, becomes essential in order to preserve dignity and self-esteem.

LOSS OF RATIONAL CONTROL (KEY STAGE CHARACTERISTIC). It is at this point that the alcoholic loses the last remnant of control over alcohol. No longer can he/she choose consistently when to drink. Remember, in the early stage, only control over how much and how long was lost. NOTE: The progression from the point of damaged control to the point of complete loss of rational control can take many years. Sometimes, it never takes place (the periodic/episodic drinker). When and if it does, however, rapid physical and psychological deterioration usyally follows.

SOLITARY DRINKING. The alcoholic knows what he/she is, and how abnormally he/she drinks; hence, the alibis, the rationalizations, and the avoidance of personal associations. Solitary drinking becomes a psychological necessity to relieve the enormous pressure created by the complexity of a life which centers around the consumption of alcohol, especially when that consumption

must remain a secret. The planning of time and concentration required to survive in such an environment (go undiscovered) are almost beyond the imagination. There is no time available to waste on social pastime. Besides, the alcoholic, at this point, has little left in common with his/her former friends. People mean pressure, excuses, embarrasements, guilt, and the possibility of being unmasked. Alone, the alcoholic is asked no questions and must tell no lies.

Characteristics of the Physiological Stage

The physiological stage starts within the middle stage. Its onset is directly connected to the loss of rational control (the loss of the ability to consistently choose when to drink). The loss of rational control leads rapidly to physical addiction (an organic craving or need). Physical addiction makes self-initiated recovery all but impossible and potentially dangerous. An unsupervised withdrawal can result in death.

MORNING DRINKING. Alcohol becomes self-administered medication to prevent withdrawal after periods of abstinence of deprivation. It is called the morning drink because the most common period of abstinence is during the night, while sleeping. However, the morning drink is applicable throughout the day. In the late stage, the onset of withdrawal can occur as soon as three to four hours after the last drink.

PROTECTING THE SUPPLY (KEY STAGE CHARACTERISTIC). The alcoholic can no longer afford to run out of alcohol. Reserves must be stored to insure an adequate supply at night and over weekends or holidays. Elaborate, sometimes unreasonable, alibis are used to cover visits to the supply. Alcohol in now the central feature of the alcoholic's life.

BLACKOUTS MORE FREQUENT. Blackouts now occur at any time without warning. They are a function of the quantity and frequency of alcohol consumption and may encompass a brief or long period of time. They are a source of much fear and anxiety, especially when they occur on the job. The alcoholic may take to keeping notes on his/her activities and conversations, least he/she forget important decisions which have been made or suspenses that have been set.

MARKED SOCIAL MISBEHAVIOR. The alcoholic's increasing fear and deterioration are manifested through hostility, irritability, declining work performance, excessive absenteeism (three times that of the average worker), and a complete breakdown of meaningful communication. Financial difficulties, legal problems, and DWI citations are common. At home, problem-solving has ceased due to the lack of communication and the survival of the marriage is in jeopardy.

OSTRACIZATION. In the middle stage, the alcoholic withdrew from his/her peers and family (solitary drinking), because of an increasing preoccupation with alcohol and the need for relief from the pressures of concealment. At this point, co-workers, friends, and family members withdrew from the alcoholic. This action represents the first real acknowledgement on their part that the alcoholic is abnormal. It is significant, however, that this acknowledgement is <u>not</u> usually recognized as such.

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Characteristics Of the Late Stage

The alcoholic is now in his/her late forties and is no longer tolerated at work, socially, or at home. Loss of job and family is imminent, if this has not already occurred.

BENDERS. Benders are extended periods of drinking which last for days, or even weeks. Money is often the controlling factor. When it runs out, the bender ends. Benders are <u>not</u> common to all alcoholics; some never experience them.

ALCOHOL SYNDROME. A syndrome is a number of symptoms occurring together which characterize a specific disease or condition. Alcoholism results in a multitude of organic problems: malnutrition, pneumonia, kidney and liver disease, paralysis, links with cancer, and heart disease. Deterioration of the central nervous system (CNS) produces extreme apathy, an inability to concentrate and solve problems, fragmentation of the memory, and profound confusion. Without medical help, death is only a matter of time and circumstances.

DEEP ANXIETY DEPRESSION. The alcohol syndrome generates undefinable fears and anxiety in the alcoholic and causes him/her to withdraw completely. The situation and any chance for recovery are viewed as hopeless. The alcoholic now follows a set routine and will not venture from known locations. To sleep with a light burning and/or a radio playing for security is not uncommon. Suicide sometimes becomes a viable alternative to survival.

COLLAPSE OF THE ALIBI SYSTEM (KEY STAGE CHARACTERISTIC). Alibis are no longer needed. Problem-concealment and people make them necessary, and both are a thing of the past. With no one or nothing left to condemn for his/her situation, the alcoholic accepts the blame.

SURRENDER. The alcoholic admits that drinking is the cause of all of his/her problems. This admission makes free choice again possible. Two options become available: (1) accept as final his/her own evaluation of the chances for recovery and surrender to death by drunkness, insanity, accident, or physical destruction; or (2) turn toward help and surrender to a long-term recovery process, which can return the individual to physical health and sociatal acceptance. The alcoholic alone has to make the decision. NOTE: Statistics indicate that only one in thirty-six choose life. The other thirty-five just die.

ALCOHOLISM IN THE HOME ENVIRONMENT

INTRODUCTION

To this point we have glanced at several approaches to etiology (causation) of alcoholism, and closely examined its characteristic progression as observed in the job environment. In this section we will take a broad brush look at some of the differences in its development in the home, exclusive of the job environment. Our study group will be primarily the unemployed housewife.

One could safely say, that strictly from an objective point of view, alcoholism is alcoholism, and that physical, psychological, and behavioral differences among alcoholics are functions of the individuals, themselves,

rather than their alcoholism. Alcoholism neither develops nor affects any two people in the same way, because no two people or their operating environment are the same, neither is their reaction to their alcoholism. To oversimplify, the only thing that two alcoholics have in common is that they both drink.

Environment and a person's individual make-up play a major role in prescribing what path, and how quickly alcoholism will progress. As stated earlier in this guide, its full development may take from 2 to 22 years and follow any number of routes. It is the environmental and personal factors that define its exact course.

When we speak of alcoholism, as it develops in women, we are primarily referring to the alcoholic housewife as this has been the primary area of research to date. This development is not necessarily restricted to women. however, it may also include the following:

Others Involved In Alcoholism

RETIRED PERSONS. The individual experiences the trauma over loss of career, and in many instances a loss of prestige. With more time on their hands, retired people drink to fill the void and reminisce about the "there and then".

THE UNEMPLOYED. These people are in a similar situation to that of the retired person. They, too, lack the meaningfulness of productivity. This lack plays havoc on their self-esteem. They experience a loss of income. This often threatens their sense of well being which in turn may increase drinking to forget their problems.

NEGELECTED CHILDREN. One of the primary causes of teen-age alcoholism is neglect. Parents who do not show the concern their children need influence them toward other sources of attention. Peer pressure, the need to be a "man" or to be "sophisticated" often lead teenagers into drinking to meet their needs for attention. They may be using a powerful drug with little knowledge as to its dangers or effects at a time when they are developing both physically and mentally.

MALE HOMEMAKERS. With the variety of accepted roles, some males may now enter into the boring and thinkless world of homemakers. He will be subjected to the rigors, stresses and strains of maintaining a home. Add to this stress his feelings of insecurity over his role identification, he could attempt to cope in the same way as the female homemaker by using alcohol.

The Home Environment

ALCOHOLISM IN THE HOME. Alcoholics in the home are harder to identify and to recognize. Due to their low structure visibility they are able to drink without being readily observed by their peers or family.

WHY IS IDENTIFICATION HARDER? The "closet-drinker" can control their own visibility to others. For the most part, their drinking patterns are not readily observable. Since they dictate their own activities and are often not accountable to anyone for their accomplishments they can drink and

structure drinking time around that activity. Identification of women alcoholics is more difficult because men often put them on a pedestal. The cultural attitude is that women are not supposed to fall and most definitely they are supposed to become alcoholics; therefore, men deny the creeping symptoms of alcoholism when they begin to occur in females.

PREMISSIVE ENVIRONMENT. As a rule, alcoholism progresses more rapidly in the home environment than on the job because the home environment is more permissive. It is unmonitored and therefore offers more opportunity to drink. There are fewer mandatory obligations and requirements on the homemaker. Since a more flexible workload exists, drinking time can be structured to allow for work and "play"; the two can be mixed.

LACK OF CHALLENGE (BOREDOM). For some homemakers life is a daily routine, lacking in reward and stimulation. Without the much needed reward and positive feedback that the worker receives, the homemaker may turn to "rewarding" herself for work done. Homemakers may also turn to socialization to relieve boredom. Their relationships with other women (or men) may include alcohol.

WOMAN'S WORK IS NEVER DONE. In some homemaker's eyes her work is never done. She is on a ship adrift from tedium to apathy and back again and may find her only relief is sleep. Relief may also come from alcohol during the day.

LACK OF APPRECIATION. She may feel significant. She may be ignored as a worthwhile and significant member of the family. There may be a lack of praise for accomplishments, and she is often taken for granted. The resulting lack of personal satisfaction may cause depression. She may turn to alcohol to help her feel better about herself.

ENVIRONMENT IS CONDUCIVE TO SUICIDAL THOUGHTS. The suicide rate for female alcoholics is higher than for the male ones. This is also true of females in general. The reason for this may be that self-identification of having a drinking problem is less likely for women. Women are generally less willing to take risks than men. Our society, in general teaches the protection of women by men and encourages women's dependence on men. Therefore, women's exposure to risk and decision-making has been institutionally limited, instilling a reluctance to risk asking for help. Furthermore, the education of women in the home about an alcoholism has been for the most part neglected.

PROFOUND SENSE OF FAILURE. Once a woman falls from the man-made pedestal she feels branded and unworthy of compassion. She will see no way to regain her self-esteem. She may feel that she has lost her right to the pedestal. Remember, she did not earn the pedestal in the first place. She was placed there by the men, simply because she was a woman. Since the pedestal cannot be earned, the recovery or regaining something that was never earned is impossible.

SENSE OF FUTILITY. The future now seems hopeless to the female alcoholic. She now sees no potential for the improvement of her lot. She feels that the final end looks like the dissolution of the family. She feels no security because of the chances of her marriage staying together are poor. She will soon have to take care of herself and this is a frightening situation for her.

Some women believe that they are second class citizens without the rights of their male counterparts. Thus death is a final, "ultimate solution". But it need not be that way. Remember they feel they are in a a caste society. They also believe that they must compete to keep their second class status. Once they fail there is little hope for recovery. Second changes are normally not available. Suicide then becomes a viable alternative.

Stages of Family Adjustment to The Alcoholic

STAGE ONE - DENIAL. The spouse will deny husband has a problem, rationalizes husband's drinking as normal. She may drink with him and/or play co-alcoholic role. She denies that disrupting family life is caused by alcoholism. She will supress own feelings and cover for spouse to others.

STAGE TWO - REGOGNITION. Wife recognized drinking pattern is not normal, She begins to chastise husband for a "lack of will power". She begins to nag thereby giving the alcoholic an excuse to drink. She struggles very hard to maintain the family structure. She assumes guilt over husband's drinking and begins to believe she is the cause of at least part of the cause of his dilemma. She is torn between the children and loyalty to her husband. She may buy his alcohol to control the amount he drinks, or pour the alcohol in the home down the drain. She will resort to "bedroom blackmail" or using sex to reward/punish drinking-nondrinking situations. Kisses may become sobriety tests.

STAGE THREE - FAMILY EQUILIBRIUM BREAKDOWN. Family equilibrium almost completely breaks down. The children are profoundly upset; the wife can no longer conceal the problem; family finances are strained. The wife begins to question her sanity.

STAGE FOUR - ATTEMPT TO MINIMIZE DISTRUPTIVE FORCES. Wife tries to minimize disruptive force of the alcoholic by reorganizing family life. She takes over completely, money, children, etc.

STAGE FIVE - DECISION TO STAY OR LEAVE RELATIONSHIP. Wife makes a decision to separate from husband or stay with him indefinitely.

STAGE SIX - FAMILY REORGANIZED WITHOUT HUSBAND. Wife and children reorganized as a family. This is sometimes done without the alcoholic's awareness. The alcoholic now becomes a scapegoat for all family problems.

STAGE SEVEN - FAMILY REUNITED IF SOBRIETY MAINTAINED. If the husband achieves sobriety, the family will try to reunite. As the husband attempts to reassume original role he is greeted with suspicion and mistrust. The family must learn that sobriety will not solve all family problems. Family reuniting is not always successful.

Assisting Families of Alcoholics

Introduce the disease concept. This will help reduce feelings of guilt and responsibility the spouse may harbor for the excessive drinking of the spouse. They must learn that the alcoholic's actions are symptoms of an illness not weak vindicative behavior.

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Spouses must recognize that they are not capable of curing the alcoholic. Once free of this burden they can drop the rescue operations. They can stop protecting the alcoholic. Referral to alanon/Alateen may be effective for them.

Child Trauma In Alcoholic Families

FORCED TO TAKE SIDES. The children live in an unstable environment. The older children tend to side with the mother against the alcoholic, protesting her younger children are frustrated and torn between both parents. They sometimes lean towards the rewards of the alcoholic father who at times rejects them causing more frustration. They sometimes blame the mother and themselves for what is wrong in the family.

UNSTABLE HOME ENVIRONMENT. The home becomes increasingly unstable because of the changing moods of the father. When under the influence his moods are unpredictable, sometimes happy, at times angry. When not drinking, his mood may be irritable. When sober he might feel guilty and overindulge the children. These moods will cause the children to formulate games to coincide with his moods.

CHILDREN ISOLATED FROM PEERS. The children are soon isolated from friends and neighbors. They are afraid to bring friends home out of fear and shame.

ROLE MODELS CONFUSED. During all of this conflict in the home the alcoholic parent is establishing a role model that could perpetrate or lead to substance abuse by the offspring in the present as well as the future. In the meantime the non-alcoholic parent is attempting to model both parental roles but finds difficulty doing both well.

SOME UNHARMED. Some children are relatively unharmed in an alcoholic family. They are generally from those homes where the spouse is aware of the children's needs and behaves with consistency and gives the children emotional support.

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EXERCISE I

Complete the following exercise.

1. If alcoholism goes untreated, what will probably result?

2. Why does the disease concept of alcoholism appear most attractive to the alcoholic?

3. How does the Air Force define alcoholism?

4. What is the most significant aspect of the Air Force's and civilian industry's approach to alcoholism?

EXERCISE II

1. Why is it difficult to prove that nutritional vitamin deficiencies and endocrine dysfunctions cause alcoholism?

2. Does the use of alcohol in the family influence the children?

3. Generally describe the Freudian and Adlerian views on the etiology of alcoholism.

   a. Freudian:

   b. Adlerian:

4. What is the basic premise of the Learning Theory?

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5. Transactional Analysis views alcoholism as the result of what action taken by the individual? When is the action taken?

a. Action:

b. When:

6. Why is the Personality Theory on the etiology of alcoholism difficult to substantiate?

7. List seven socio-cultural factors which influence an individual toward alcoholism.

a.

b.

c.

d.

e.

f.

g.

8. According to R. F. Bales, in what three general ways do cultural organization and social organization influence a society's rate of alcoholism?

a.

b.

c.

EXERCISE III

1. What are the <u>major</u> characteristics of the pre-alcoholic stage?

a.

b.

c.

d.

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2. Does the pre-alcoholic stage show any identifiable patterns of drinker behavior or set of drinker traits?

3. What dictates the drinking habits in the pre-alcoholic stage?

4. How might the orgin of an alcoholic's psychological dependence on alcohol be describes?

EXERCISE IV

1. What are the major Characteristics of the early stage?

   a.

   b.

   c.

   d.

2. What is the alcoholic's primary reason for drinking in this stage?

3. What is meant by damaged control?

4. Why is the periodic (episodic) drinker placed in this stage?

EXERCISE V

1. What are the major characteristicsof the middle stage?

   a.

   b.

   c.

   d.

   e.

2. What is the key characteristic of the middle stage?

3. What is the difference between damaged control and the loss of rational control?

4. Why does the alcoholic rationalize his/her drinking behavior?

5. What does solitary drinking provide the alcoholic?

EXERCISE VI

1. What event marks the onset of the physiological stage?

2. What are the major characteristicsof the physiological stage?

   a.

   b.

   c.

   d.

   e.

3. What is the Key characteristic of the physiological stage:

4. What is significant about ostracization?

EXERCISE VIII

Complete the following exercise.

1. What are the major characteristics of the late stage?

   a.

   b.

   c.

   d.

   e.

2. Are benders common to all alcoholics?

3. What symptoms are associated with CNS deterioration?

4. What big step does the alcoholic take with the collapse of the alibi system?

EXERCISE VIII

1. Identify four other members of our society that have also been associated with alcoholism.

   a.

   b.

   c.

   d.

2. Why is it difficult to identify the home alcoholic?

EXERCISE IX

1. What are seven stages of family adjustment to the alcoholic?

   a.

   b.

   c.

   d.

   e.

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f.

g.

2. What are some problems encountered by children whose parents are alcoholics?

a.

b.

c.

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ANSWERS TO EXERCISES

Exercise I

1. It usually worsens, rather than improves.

2. It removes the stigma attached to alcoholism and lessens the guilt carried by the alcoholic.

3. As a psychological or physical dependency on alcohol.

4. Each approach emphasizes immediate assistance for the individual as opposed to delaying positive action until a specific label for his/her condition has been determined.

Exercise II

1. Because all the people studied are already alcoholic, and it cannot be determined whether or not these conditions existed prior to the alcoholism. Additionally, all people with vitamin deficiencies and/or endocrine dysfunctions do not predictably become alcoholics.

2. Yes, through example, opportunity, and availability.

3. a. Alcohol releases the inhibitions, allowing the expression of repressed urges. Alcoholism results from a person's overwhelming need to express these urges.

   b. Overindulgent parents prevent the child's learning to cope with life problems, resulting in feelings of inferiority and low self-esteem. Alcohol compensates for these feelings by bolstering feelings of power and worth.

4. Drinking is selected as a repeated behavior through positive, unconscious conditioning or reinforcement.

5. a. An early decision.

   b. In the person's childhood.

Atch 1

6. Because those people studied are already alcoholic, and it cannot be determined whether or not any predisposition toward alcoholism existed. Additionally, people who demonstrate the "alcoholic personality" do not necessarily become alcoholic.

7. a. Cultural ambivalence.

   b. Lack of cultural integration.

   c. Peer-group pressure.

   d. Family group.

   e. Sanctions.

   f. Encouragement.

   g. Alternatives.

8. a. By "the degree to which culture operates to bring about acute needs for adjustment, or inner tensions, in its members."

   b. By "the sort of attitudes toward drinking which the culture produces in its members."

   c. By "the degree to which the culture provides suitable substitute means of satisfaction."

Exercise III

1. a. Increasing quantities of alcohol consumed.

   b. An increasing frequency of drinking episodes.

   c. Occasional intoxication.

   d. Hangovers.

2. No.

3. The peer group.

4. As the point when the alcoholic begins to look forward to drinking as an integral and important element in his/her life.

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Exercise V

1. a. Alibi system.

   b. Changing drinking pattern.

   c. Rationalization.

   d. Loss of rational control.

   e. Solitary drinking.

2. Loss of rational control.

3. Damaged control is the inability to consistently choose how much or how long one will drink. Loss of rational control is the inability to consistently choose when to drink.

4. To preserve dignity and self-esteem.

5. Psychological relief from the enormous pressure created by the complexity of a life that centers around the consumption of alcohol.

Exercise VI

1. The loss of rational control over alcohol.

2. a. Morning drinking.

   b. Protecting the supply.

   c. Blackouts more frequent.

   d. Marked social misbehavior.

   e. Ostracization.

3. Protecting the supply.

4. It represents the first real acknowledgment on the part of co-workers, friends, and family that the alcoholic is abnormal.

Exercise VII

1. a. Benders.

   b. Alcohol syndrome.

   c. Deep anxiety depression.

   d. Collapse of the alibi system.

   e. Surrender.

2. No.

3. a. Extreme apathy.

   b. An inability to concentrate and solve problems.

   c. Fragmentation of the memory.

   d. Profound confusion.

4. The alcoholic accepts the blame for his/her situation and admits that drinking is the cause of all of his/her problems. A surrender to recovery is now possible.

Exercise VIII

1. a. Retired persons
   b. The unemployed
   c. Neglected children
   d. Male homemakers
2. Their drinking patterns are not readily observable.

Exercise IX

1. a. Denial
   b. Recognition
   c. Family equilibrium breakdown
   d. Attempt to minimize disruptive forces
   e. Decision to stay or leave relationship
   f. Family reorganized without husband
   g. Family reunited if sobriety is maintained
2. a. Forced to take sides
   b. Isolated from peers
   c. Role models confused

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Social Actions Training Branch
Lackland Air Force Base, Texas

HO 3ALR73430B/30LR7361B/
30ZR7364B-II-7-15
8 February 1978

ALCOHOLISM ROLES WORKSHEET

ROLE-PLAYING SITUATIONS

ROLE ONE (Member of the Social Actions Office):

You have arranged a meeting with MSgt Jones, the supervisor of TSgt James, who is to be accompanied by his wife. MSgy Jones has asked that you mediate this meeting, since he cannot effectively confront TSgt James with his deteriorating work habits.

ROLE TWO (Alcoholic):

You are in your thirities, with approximately ten years of service, possess demonstrated abilities, and are a key employee at work. Promotions have moved you into a position of responsibility. However, unfavorable manifestations of your problem drinking are affecting your job performance, as well as family and community relations. You are becoming more and more dependent on alcohol as the only tried and proven source of relief from disconfort, both psychological and physical.

Supersedes HO B-(9)-15; 14 Jan 75

ROLE THREE (Alcoholic's Wife):

You are a housewife in your thirties, with one child ten years of age. You suspect that your husband has a drinking problem or is an alcoholic. His habit has been increasing for the past four or five years. He is spending far too much money and no longer handles the budget. At home, he pays little attention to the family, and is often irritable. When confronted, he either ignores your concern, rationalizes his behavior, or leaves the house.

ROLE FOUR (Supervisor):

Your employee is in his thirties, has demonstrated his abilities, and now holds a key position of responsibility. However, a dark cloud is beginning to cast a shadow on his career. Certain unfavorable signs are showing up in his job performance. Absenteeism, a decrease in overall work quality, and non-typical behavior patterns, such a nervousness, irritability, and conflicts with fellow workers, are developing.

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ROLE = SPOUSE	CONSENSUS RESPONSE
How do you feel about discussing the problem with him?	
How do you feel about his broken promises concerning drinking?	
How much do you choose to ignore in his behavior?	
How do you feel about doing research about alcoholism on the sly?	Books Friends Counseling
What do you know about available sources of assistance? Would you use them?	AA ALANON Chaplain, Social Actions Office
What methods, subtle or open, do you use to confront him with his problem?	Direct? Indirect?
How do you feel about gradually assuming the role of both parents?	
How do you feel about the future of your children and family? If concerned, what will you do?	
Do you view separation or divorce as a possibility?	
How do you feel about defending your husbands behavior in public?	
How do you feel toward your friends and parents?	

PLAN OF INSTRUCTION/LESSON PLAN PART I

NAME OF INSTRUCTOR	COURSE TITLE
	Drug and Alcohol Abuse Control
BLOCK NUMBER: II	BLOCK TITLE: Basic Skills and Knowledges

1 COURSE CONTENT	2 TIME
7. History of Drug/Alcohol Abuse a. Identify historical development which led to the formulation of current Air Force policies and programs on drug/alcohol abuse. SUPPORT MATERIALS AND GUIDANCE Student Instructional Material HO B-II-8-7, History of Drug/Alcohol Abuse Audio-Visual Aid 35mm Slides, History of Drug/Alcohol Abuse Training Method Lecture Instructional Guidance Present a historical perspective of man's involvement with drugs and alcohol, with special emphasis on the Twentieth-Century trends in the United States. Discuss the many attempts to control the use and abuse of drugs and alcohol and the effects the attempts had on consumption. 8. Review, Measurement and Critique a. Review b. Measurement c. Critique	

SUPERVISOR APPROVAL OF LESSON PLAN (PART II)

SIGNATURE AND DATE	SIGNATURE AND DATE

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PART II - TEACHING GUIDE

INTRODUCTION (10 Minutes)

ATTENTION

Why learn about the history of drug and alcohol abuse? If it weren't for this generation's shooting grass and smoking speed, there wouldn't be a drug and alcohol problem.

MOTIVATION

1. Some of the people you will be dealing with in the drug and alcohol field actually believe such misinformation.

2. Problems with drugs and alcohol have existed since civilization began. Many ways of dealing with them have been tried (most were unsuccessful). We are different and can be more successful if we can learn from historical mistakes.

OVERVIEW

In today's lesson, we will be taking a look at the historical developments which led to our present policy on drug/alcohol abuse control. More specifically. we will discuss:

1. Historical perspectives of opium, morphine, heroin and cocaine.

2. Historical perspectives of barbiturates, amphetamines, LSD, and mescaline.

3. Historical perspectives of marijuana and alcohol.

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4. Significance of pharmacological revolutions.

5. Federal policy and its effects on Air Force policy.

TRANSITION

BODY (2 Hours 40 Minutes)

PRESENTATION

7a. CRITERION OBJECTIVE: Identify historical developments which led to the formulation of current Air Force policies and programs on drug/alcohol abuse.

1. Discuss historical perspectives of opium, morphine, heroin, and cocaine.

a. Opium (16:181-186).

(1) Origin - explain written story begins about 400 B.C.

(a) Reference "Joy Plant" on Sumarian tablet.

(b) Same symbol appears 3300 years later with method of harvest.

(c) Used in Egypt, Greece, India, China, and Arabia.

(2) Expansion of use - expansion due largely through Arabian camel trains.

(3) Colonial use - (1600-1800).

(a) Therapeutic agent, pain reliever, cure for venereal disease, gallstones, and dysentery.

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(b) Lack of knowledge about addiction.

(c) Available from physicians, druggists, grocery stores, patent medicine sellers, and mail order catalogs.

(d) Use stimulated by writers.

(e) Opium eating and drinking popular in upper and middle classes.

(f) Opium smoking associated with Chinese laborers.

(4) Regulatory efforts (4:42-46).

(a) 1800's - Anti-opium laws passed in San Francisco, California and Virginia City, Nevada.

1. Racist laws.

2. Failed.

3. Attitudes.

a. (1700's to middle 1800's) Users had lack of will-power. Use considered a vice.

b. (Late 1800's to early 1900's) Change in attitudes because of knowledge of addiction (16:188).

(b) Legislation of 1900's (4:47).

1. Pure Food and Drug Act 1906.

a. Opium content in medicine had to be indicated on product label.

b. Educational campaigns for the law caused decrease in patent medicine use.

2. Harrison Narcotics Act 1914 (4:49).

a. Created due to international obligations, not concern for domestic morality.

b. Designed to fulfill agreements.

c. Designed as means of drug taxation.

d. 1915 Supreme Court decision that possession of smuggled opiates was a crime and users not obtaining drugs from physicians became criminals (16:190-191).

e. 1920 Webb and 1922 Behrman decision made it illegal to prescribe drugs to addicts.

f. 1925 decision reversed these but physicians were too harrassed to change procedures.

(5) Effects of legislation.

(a) Legal benefits of Pure Food and Drug Act were now removed.

(b) Legal sources of narcotics were now being replaced by underground supplies.

(c) Prices for these drugs rose, setting the stage for all the illegal activities that have been associated with addiction ever since.

(d) Law enforcement approach was accepted as the only workable solution to the problem of addiction.

(e) "Tightening up" has not caused a decrease in current use.

b. Morphine.

(1) Origin and usage.

(a) Sythesized from opium in 1804.

(b) Developed as a cure for opium addiction.

(c) Ten times more potent than opium.

(d) Opium addicts were transferred from one drug to another.

(e) Hypodermic syringe (1853); common misconception that morphine, when injected, would not cause addiction.

(f) Uncontrolled use in military medicine during mid-1800's created "soldier's disease" (morphine addiction) (18:-1-11).

(2) Describe the contemporary use of morphine.

(a) Legally used in medicine.

(b) Decrease in illegal used due to greater desirability of heroin.

c. Heroin (16:189).

(1) Discovery and usage.

(a) Chemical modification of morphine.

(b) Developed as "hero" drug (1874) to cure morphine addiction.

(c) Although thought to be safe as aspirin, was ten times more potent than morphine.

(d) Potency transferred morphine users to heroin; attracted thousands more.

(e) Established the hypodermic syringe as an instrument of drug abuse.

(2) Describe regulatory efforts against heroin.

(a) Congress prohibited manufacture in 1924.

(b) Stocks of pharmacies and manufactures were surrendered to government in 1956.

(3) Contemporary use.

(a) Medical use practically nonexistent.

(b) Federal Bureau of Narcotics (1969) -- one in three thousand addicts.

d. Cocaine (16:158-161)

(1) Discovery and usage.

(a) Coca leaves.

1. Used by Incas in religious ceremonies, to allay hunger, fatigue of messengers. Troops considered it more valuable than silver or gold.

2. Pizzarro's conquest 1532, used coca leaves to pay slave labor (cheaper than silver or gold).

3. Use of coca leaves considered work of the devil by the Catholic church until Pope Leo XIII tried it, liked it, and approved of it.

(b) Cocaine.

1. Isolated as active element in coca leaves in 1858.

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2. Medically used as a legal anesthetic.

996

3. Used by Sigmund Freud to deal with depression and anxiety. Praised and prescribed its use until it caused the death of a friend.

4. Used by German Army doctor (1883) to help combat fatigue of troops.

5. Late 1800's, used in many tonics and soft drinks. In 1886, Coca Cola created and advertised as a cure for melancholia (decocainized coca leaves used now).

6. In the 1890's, doctors became aware of the addicting and psychotic effects.

(2) Describe the contemporary use of cocaine.

(a) Cocaine replaced by amphetamines which are cheaper and more easily available.

(b) Recent gradual return to cocaine due to tightening of amphetamine sources.

APPLICATION/EVALUATION

1. Why were the first anti-opium laws passed?

2. What caused a change in the attitudes toward opium use?

3. What were the provisions of the Pure Food and Drug Act of 1906?

4. What were the effects of the Harrison Narcotics Act of 1914?

5. Why were morphine and heroin developed?

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2. Discuss historical perspectives of Dangerous Drugs, Barbiturates, Amphetamines, LSD, and Mescaline.

a. Barbiturates (16:173-176).

(1) Origin.

(a) Reason(s).

1. During the late 1800's a wide range of sedatives and hypnotics were available to deal with anxiety and insomnia.

2. Negative qualities of bromide salts (bromide poisoning), chloral hydrate (bad taste, smell), and alcohol (objectionable to teetotalers) caused search for better drug.

(b) Synthesis - 1862 by Dr. Bayer.

(c) Distribution.

1. 1903 - barbital (barbituric acid derivative) was first distributed.

2. 1912 - phenobarbital was distributed.

(d) Medical popularity - became popular among physicians and patients to deal with insomnia, high blood pressure, epilepsy, etc.

(2) Regulatory efforts.

(a) During 1940's, major campaign against nonmedical use began.

(b) American Medical Association published articles with message to avoid careless, illicit use.

(c) States passed laws against non-prescription use.

(d) Arrests for use and suppression by US Food and Drug Administration agents created publicity.

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(a) Publicity aroused interest, warnings became lures, and use increased.

(3) Contemporary use and production.

(a) Prescribed and used medically.

(b) Production - 1969.

1. Enough to provide 40 doses for every person in the United States.

2. Up 800% since 1942.

3. One-half of production enters illicit market.

b. Amphetamines (16:161-172).

(1) Origin and use.

(a) Synthesized in 1887.

(b) Medical use not noted until 1927. Subsequently used to deal with:

1. Blood pressure difficulties.

2. Bronchial problems.

3. Narcolepsy (sleeping sickness).

4. Hyperactive children.

(c) Used during World War II by American, British, German, Japanese forces to counteract fatigue, elevate mood, heighten endurance, etc.

(d) Prescribed medically after the war for depression, weight control, etc.

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(2) Recreational use in the 1900's.

(a) Tablets.

1. The 1930's to the present.

2. Replaced caffeine tablets for truck drivers, students, etc.

3. Periodic drives to curb illicit market traffic were counterproductive.

a. Arrests advertised the product.

b. Arrests increased the risk and price, thus attracting new illicit producers.

c. In 1962, four and one-half billion tablets were produced. One-half of that amount entered illicit markets.

(b) Intravenous injections.

1. Custom brought back from service personnel in Korea and Japan during the 1950's.

2. During the 1960's, there was a great campaign against traditional "hippie" drug (marijuana, Lysergic Acid Diethylamide LSD).

a. "Scare" tactics caused a change for the worse -- people turned to speed.

b. Greater problems with speed caused a general youth distrust of authority and drug information.

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1000

c. Lysergic Acid Diethylamide (16:232-248).

(1) Origin.

(a) Albert Hoffman.

1. Synthesized LSD on 1938.

2. Accidently injested some in 1943.

(b) Unlike other drugs, LSD became a drug in search of use.

1. Army tested it and then stockpiles it for the possibility of brainwashing enemy forces.

2. Psychotherapists used it to understand and treat psychotic patients.

3. Used to treat alcoholism.

4. Eased pain for terminal cancer patients.

5. Major difficulty in use is unmanageability.

(2) Regulatory efforts.

(a) Prior to 1962 used only on a small scale.

(b) Labeled by Food and Drug Administration as an investigational new drug (IND).

(c) In 1962, another IND, Thalidomide created birth-defect problems.

(d) After thalidomide problems, FDA tightened up on all IND's.

(e) Congress passed a law restricting IND's.

(f) Many states outlawed LSD because it was an IND.

(g) Drug companies limited LSD distribution.

(h) Restrictions created publicity.

(3) Effects of legislation.

(a) Publicity aroused interest.

(b) Interest created demand.

(c) Due to ease of synthesis production, supply then exceeded US demands.

(d) The United States became a worldwide LSD exporter.

(e) Estimates of people who have taken LSD range from 40,000 to 1,000,000 in the United States.

d. Mescaline (16:215-220)

(1) Discovery and usage.

(a) Hallucinogenic alkaloid extracted from peyote cactus. First identified in 1886.

(b) Peyote cactus.

1. Used by Aztecs in Mexico for medicinal, religious purposes. Referred to as "flesh of Gods."

2. Excommunicated by Spanish missionaries, who had own ideas about God's flesh.

3. Ritual use of peyote spread to Indians in the United States.

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4. Mid-1800's, peyote cult established rituals and practices.

a. Stressed Pan-Indian nativism.

b. Provided Indian identity, unity.

c. Aided in acceptance of white domination.

(2) Regulatory efforts.

(a) Continuous fight for efforts against mescaline.

(b) Acceptance, however, of Indian religious use.

(3) Contemporary use.

(a) During the 1950's and 1960's, common use spread. Mail order companies that supplied Indian tribes advertised in colleges.

APPLICATION/EVALUATION

1. What was the effects of legislation on barbiturate use?

2. Why did drug users in the 1960's distrust drug authorities and drug information?

3. Why is LSD unique among all the drugs regarding use?

1003

3. Discuss Historical Perspectives of Marijuana and Alcohol.

a. Marijuana (16:251-254).

(1) Early history.

(a) 2737 BC - Medical uses: Female weakness, gout, rheumatism, malaria, beriberi, constipation, absentmindness.

(b) Arabic legend - monks who took hashish, and were transferred from austere asetics into jolly good fellows.

(c) Other references.

1. India.

2. China.

3. Middle East.

(d) 430 BC - Cannabis as an inebriant. Burning of seeds and inhaling smoke. (Scythians as reported by Herodotus.)

(e) 1000 AD - Moslem world and North Africa. Social use considered epidemic in 12th century.

(f) 1299 - Cult of "Hashishiyya".

(2) American History.

(a) 1611 - brought to Jamestown as important crop.

(b) 1762 - Virginia levied fines for not growing.

(c) Replaced as crop by cheap imported hemp.

(d) Expansion in growth as a crop during war periods.

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(e) Non-recreational use.

1. Medicine.

2. Pharmacy journal.

3. Migrane headaches.

4. Over the counter drugs - 19th and early 20th century.

5. Decline in medicinal use.

(f) Recreational use.

1. Very little prior to 20th century.

2. Spread of popularity.

a. Perishing troops.

b. Sailors of New Orleans.

c. Mexican laborers.

3. Use limited to:

a. Local.

b. Temporary.

(3) Regulatory Efforts.

(a) Volstead Act 1920 (4:410).

1. Increase alcohol price.

2. Decrease quantity/availability of alcohol.

3. Marijuana seemed more attractive.

(b) Louisiana crime wave (1930's).

(c) Marijuana Tax Act 1937 (9:2).

1. Resulted from publicity about marijuana crimes.

2. Director of Bureau of Narcotics Harry Anslinger's testimony.

(4) Research data.

(a) LaGuardia Report 1938 - Published 1944 (16:257-258).

1. Tolerance.

2. Personality.

3. Doesn't lead to opiates.

4. No physical, mental or moral degeneration.

(b) Current research (23:1-29).

1. Clinical possibilities speculative - no good evidence that marijuana smokers have impairment in physical body functions.

2. No evidence as to definite value for inhibiting human cancer growth.

3. No evidence of impaired neuropsychologic test performance in humans.

4. In college populations - those who are more hypochrondrical, and who feel less in control of their own lives and more at mercy of external events are more likely to have adverse reactions to marijuana and other psyco-active drugs.

5. Accumulated evidence that marijuana at typical social levels definitely impairs driving ability and related skills.

6. Tolerance develops with prolonged use.

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7. Delta-9-THC shows definite promise of becoming an effective agent for management of glaucoma.

8. Delta-9-THC shows promise as a means of reducing, or eliminating the nausea, vomiting and loss of appetite in cancer patients following chemotherapy.

9. Delta-9-THC shows promise of developing improved treatment methods in the management of asthmatics.

10. Chronic use research is limited.

b. Alcohol.

(1) Origin and early history (3:13-15).

(a) Agricultural way of life.

(b) Archaeological evidence.

1. Beer and berry wine known and used about 6400 BC.

2. Beer - Egypt 4500 BC.

3. Wine Decanters 900 BC.

4. Alcohol commerce 2500 BC.

5. Supression of drinking 2000 BC.

6. Heavy drinking 1500 BC.

7. Wine ration 1100 BC.

(2) Early American use (16:81-85).

(a) Widespread acceptance.

(b) Help for harsh weather.

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(c) Puritans, Quakers.

(d) Indians.

(3) Economic influences.

(a) Triangle trade.

(b) "Buy American - Drink American".

(c) Wages.

(d) Military ration.

(e) Whiskey rebellion (late 1700's).

(4) Regulatory efforts.

(a) Spread of temperance.

1. Slow but impressive.

2. Clergy, business, physicians, congress, etc.

3. Formation of temperance organizations.

(b) Fluctation of legislation.

1. 1850's - 13 States had prohibition laws.

2. 1860's - repeal of laws.

3. 1880's - 8 States had prohibition laws.

4. 1904 - Laws repealed.

5. 1917 - 35 States were dry.

6. 1919 - entire nation dry.

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(c) Prohibition era - 1920-1933.

1. Removal of federal standards for manufacture.

2. Wine/beer replaced by hard liquor.

3. 24 hour speakeasies replaced with legal saloons with normal closing hours.

4. Organize crime involved in:

a. Production.

b. Distribution.

c. Sale.

5. Repeal of law.

(5) Contemporary use:

(a) Same per capita as mid 1800's.

(b) Shift back to beer/wine.

(c) 10 million people with drinking problems (1974 HEW).

APPLICATION/EVALUATION

1. What was the significance of the Volstead Act of 1920?

2. What were the effects of prohibition?

TRANSITION:

1009

4. Discuss pharmacological revolutions (16:3-5).

a. Use of vaccines - brought major communicable diseases under control.

b. Introduction of Sulfa drugs - save and prolong life.

c. Advent of tranquilizers - for treatment of mentally ill.

(1) Development of 1950.

(2) Widespread use in 1954.

(3) Effects on culture:

(a) Used for effect on mind, not body.

(b) Return one's mental health to normal.

(c) Tranquilizers were acting same way as antibiotics did - to remove the disease.

(d) Decrease in hospitalized schizophrenic persons.

(e) Established chemotherapy as the only effective procedure available for the treatment of severely disturbed individuals.

d. Development of Oral Contraceptives.

(1) Effects largely unknown.

(2) Change in attitudes and behavior.

(3) Probable demise of family as basic unit of our social structure.

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(4) Development of equal rights.

(5) Impact - for the first time, potent chemicals labeled as drugs are being widely used by healthy people because of their social convenience. INSTANT PLEASURE.

1010

e. Other predictable revolutions.

(1) Development of euphoriants - drugs that alter the body for pleasure. Makes possible to select effect desired.

(2) Smart Pills - increase learning ability.

(3) Possible increase in use of Psychoactive drugs by normal people in next 30 years.

APPLICATION/EVALUATION

1. What is the significance of pharmacological revolutions?

TRANSITION:

1011

5. Discuss Federal policy and its effects on Air Force policy.

a. State a policy definition - "Whatever governments choose to do or not to do." (6:1)

b. Explain objectives of Federal policy on drug abuse.

(1) Supply reduction.

(a) Control supply.

(b) Reduce supply.

(2) Demand reduction.

(a) Dissuade non-user from experimenting.

(b) Deter occassional user or experimenter.

(c) Make treatment available for abusers who seek it.

(d) Help former abuser regain his/her place as a productive member of society.

c. Explain how objectives are accomplished.

(1) Drug abuse prevention is accomplished through the Department of Health, Education and Welfare (DHEW) largely through efforts of National Institute of Drug Abuse (NIDA).

(a) Define drug abuse as a Social and Medical problem.

(b) Propose treatment and Social remedies for those involved.

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(2) Drug Law Enforcement - accomplished through the Justice Department by Drug Enforcement Administration (DEA).

1012

(a) Define drug abuse as a criminal problem.

(b) Prescribe legal sanctions for those involved.

d. Problems with having two approaches to drug abuse control.

(1) Overlapping of clientele.

(2) Duplication of efforts.

(3) Confusing to clients.

(4) Counterproductive to treatment/rehabilitation.

e. Conflicts due to having no clearly defined roles for two departments.

(1) No mutually supportive relationship.

(2) Relationship never defined.

(3) Competition between two creates problems for clients, administrators and taxpayers.

(a) Each seeks larger budgets.

(b) Each seeks more visibility than the other.

f. Explain policy formulation that led to present drug prevention/enforcement structure.

(1) Presidential Reorganization Act on April 8, 1968 created Bureau of Narcotics.

(a) Merger of Treasury Department's Bureau of Narcotics and Food and Drug Administration's Bureau of Drug Abuse Control.

(b) Placed under the Justice Department.

1. Reinforces values of law and order.

2. Adds to judicial Administrative functions for drug abuse policy.

3. Judicial history - possession for one's own use of any controlled substance is always a misdemenor for the first offense.

(c) Established to more effectively control illicit use of narcotics and dangerous drugs.

(d) Responsible for:

1. Enforcement of laws and statutes relating to narcotic drugs, marijuana, depressants, stimulants, and hallucinogenics.

2. Regulation of legal trade in narcotic drugs.

(2) Controlled Substance Act of 1970 (22:28-32).

(a) Purpose - minimize quantity of drugs of abuse which are available to persons who are prone to abuse drugs.

(b) Gives authority to Attorney General to place drugs into five schedules based on their potential for abuse.

(c) Agencies responsible for enforcement.

1. Food and Drug Admin.

2. Drug Enforcement Admin. (DEA) in the Department of Justice.

(d) Rationale for Act - reassertion of the faith of Congress in the efficacy of the criminal sanction.

(3) 1971 Campaign to eradicate Drug Abuse.

(a) Drug abuse declared "public enemy number one."

(b) Purpose - eliminate nonmedical use of drugs in the U.S.

1. Eliminate drug abuse as a profitable criminal activity.

2. Halt illicit drug traffic and cause addicted persons to seek treatment rather than face harsh criminal penalties.

(4) Drug Abuse Office and Treatment Act of 1972.

(a) Created Special Action Office of Drug Abuse Prevention (SAODAP).

1. Established National Institute of Drug Abuse (NIDA) as lead agency in Department of Health, Ed., and Welfare (DHEW).

2. Mandate for SAODAP did not extend to policy formulation and coordination between prevention and law enforcement.

(b) Added a vigorous prevention and treatment component to the existing law enforcement efforts.

(c) SAODAP expired on June 30, 1975.

(5) Failure to provide funds for Office of Drug Abuse Policy for coordinating Drug Abuse Prevention and Law Enforcement.

g. Air Force policy largely a reflection of this Federal Policy - AF policy has already been discussed in detail in an earlier segment.

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h. Discuss results of policy.

(1) Intended.

(a) Limit supply.

(b) Control use.

(c) Prevent use and distribution.

(2) Unintended.

(a) Increase black market.

(b) Increase profits of racketeers.

(c) Reinforce religious aspects that view drug abuse as sinful.

(3) Other effects:

(a) Sets culture back.

(b) Stifles humanistic movements toward abusers.

(c) Increases alienation of large segments of society.

(d) Increases taxes to pay for increase law enforcement efforts.

APPLICATION/EVALUATION

1. Define the term "policy".

2. What are the objectives of our Federal Policy on Drug/Alcohol Abuse?

CONCLUSION (10 Minutes)

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SUMMARY

Restate main points of lesson.

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REMOTIVATION

As drug/alcohol educators and counselors, we are a viable alternative to various unsuccessful ways of dealing with drug and alcohol abuse problems. What we are doing will someday be history. Let us make sure we do our part to insure that we have made changes for the better.

CLOSURE

Quote from E.M. Brecher, Licit and Illicit Drugs. "There is little likelihood that further tinkering with the laws will prove more successful than the hundreds of such laws already on the books. Legislators who trust in such measures are failing to face the facts. Narcotic addiction remains endemic despite the most ingenuous laws and vigorous law enforcement. The time has come to end our dependence on repressive legislation and law enforcement as a cure for the narcotics evil, and to explore more rational alternatives."

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CORRECTED COPY

STUDY GUIDE

3ALR73430B/30LR73618/30ZR73648-II-7-1

- Technical Training

DRUG AND ALCOHOL ABUSE CONTROL

Basic Skills and Knowledges

HISTORY OF DRUG/ALCOHOL ABUSE

1 November 1977

HEADQUARTERS 3250 TECHNICAL TRAINING WING (ATC)
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ATC FORM 214 (LAN 79) OBSOLETES ATC FORMS 214, MAY 68, 522, NOV 68 AND 523, MAY 71. STANDARD COVERSHEET

1020

7a. Identify the origin, recreational and non-recreational uses, and the effects of regulatory control of the narcotic drugs.

Opium

1. Regulatory efforts (China)
   a. Reasons for.
   b. Effects of.
2. Recreational, non-recreational use (U.S.)
   a. Early ideas
   b. Availability.
3. Regulatory efforts.
   a. San Francisco, New York City
      (1) Reasons for.
      (2) Effects of.
   b. Attitudes toward users.
      (1) 1700's - Mid-1800's.
      (2) Late 1800's - Mid-1900's.
   c. Pure Food and Drug Act - 1906.
      (1) Reasons for.
      (2) Effects of.
   d. Harrison Narcotics Act - 1914.
      (1) Reasons for.
      (2) Effects of.

Morphine

1. Recreational and non-recreational use.

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a. Early ideas.

b. Effects of.

Heroin

1. Recreational and non-recreational use.

a. Early ideas.

b. Effects of.

2. Regulatory efforts.

a. Effects of.

Cocaine

1. Recreational and non-recreational use.

a. Incas.

2. Regulatory efforts.

a. Reasons for.

b. Reasons for change.

7b. Identify the origin, recreational and non-recreational uses, and the effects of regulatory control of the dangerous drugs.

Barbiturates

1. Origin.

a. Reasons for.

2. Regulatory efforts.

a. Reasons for.

b. Effects of.

Amphetamines

1. Recreational and non-recreational use.

a. Non-recreational.

b. Recreational.

2. Regulatory efforts.

a. Reasons for.

b. Effects of.

Lysergic Acid Diethylamide (LSD)

1. Recreational and non-recreational use.

a. Non-recreational.

b. Recreational.

2. Regulatory efforts.

a. Reasons for.

b. Effects of.

Mescaline

1. Recreational and non-recreational use.

a. Viewpoint.

2. Regulatory efforts.

a. Reasons for.

b. Status of.

7c. Identify the origin, recreational and non-recreational uses, and the effects of regulatory control of marijuana.

1. Recreational and non-recreational use.

a. Non-recreational.

(1) Agricultural.

(2) Medical.

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b. Recreational.

(1) Introduction.

(2) Degree of use.

2. Regulatory Efforts.

a. Volstead Act - 1920.

(1) Effects of.

b. Louisiana crime wave - 1930's.

(1) Reasons for.

(2) Effects of.

c. Marijuana Tax Act - 1937

(1) Reasons for.

(2) Effects of.

d. LaGuardia Committee Report - 1944.

(1) Findings.

3. Current situation.

a. Recreational and non-recreational use.

b. Regulatory efforts.

7d. Identify the recreational and non-recreational uses, economic influences, and the effects of regulatory control of alcohol.

1. Regulatory efforts (Egypt).

a. Reasons for.

b. Effects of.

2. Economic influences (U.S.)

a. Trade.

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b. Wages.

3. Regulatory efforts.

a. Whiskey insurrection - 1794.

b. Temperance movements.

c. Legislation.

d. Prohibition (1920 - 1933).

(1) Reasons for.

(2) Effects of.

4. Contemporary use.

a. Consumption.

b. Problems.

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PLAN OF INSTRUCTION/LESSON PLAN PART I

NAME OF INSTRUCTOR	COURSE TITLE
	Drug and Alcohol Abuse Control
BLOCK NUMBER	**BLOCK TITLE**
III	Counseling Techniques

1 COURSE CONTENT	2 TIME
1. Counseling Techniques COUNSELING TECHNIQUES (INDIVIDUAL) a. Identify the basic principles of individual counseling. COUNSELING TECHNIQUES (Transactional Analysis/Gestalt) b. Identify Transactional Analysis and Gestalt techniques shown to be useful in social actions counseling. COUNSELING TECHNIQUES (Dreikurs and Beier-A Responsibility Model c. Identify principles and techniques of coping with Dreikurs' classical misbehaviors when they occur in counseling sessions. COUNSELING TECHNIQUES (Counseling the Alcoholic) d. Identify basic principles and techniques for counseling alcoholic clients. COUNSELING TECHNIQUES (Referrals) e. Identify the steps in establishing and maintaining meaningful referral resources. f. Identify the correct procedure for conducting referral interviews and providing appropriate referral follow-up. COUNSELING TECHNIQUES (Values Clarification) g. Identify principles and techniques of values clarification.	

SUPERVISOR APPROVAL OF LESSON PLAN (PART II)

SIGNATURE AND DATE	SIGNATURE AND DATE

PLAN OF INSTRUCTION NUMBER	DATE	PAGE NO.
L3ALR73430B/L30LR7361B/L30ZR7364B	30 May 1978	29

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COUNSELING TECHNIQUES (Viable Alternatives)

h. Identify methods of identification and promotion of viable alternatives to drug/alcohol abuse.

i. Given a dyad role-playing situation and the Viable Alternatives Interview Worksheet, satisfactorily guide a client through the viable alternatives process using the worksheet in accordance with the criteria listed on the worksheet.

COUNSELING TECHNIQUES (Role-Playing Practicum)

j. Given an approved drug/alcohol role-playing situation for the client, satisfactorily counsel the client in accordance with the Counseling Practicum Performance Test.

COUNSELING TECHNIQUES (PERSONNEL PROCESSING SQUADRON DISCHARGEE PRACTICUM)

k. Placed in an actual counseling environment, establish a satisfactory counselor/client relationship and effectively use crisis intervention techniques in accordance with the criteria listed in the Dischargee Counseling Practicum Performance Test.

SUPPORT MATERIALS AND GUIDANCE

HO B-III-1-1, Counseling Techniques Handout
SW B-III-1-2, Counseling Techniques Study Guide/Workbook
HO B-III-1-3, Criterion Objectives (Block III)
SW B-III-1-4, Viable Alternatives Worksheet
HO B-III-1-5, Counseling Techniques Practicum (PERPRON)
PT B-III-1-7, Counseling Techniques Practicum Performance Test
PT B-III-1-8, Dischargee Counseling Practicum Performance Test

Audio-Visual Aids
16mm Film, Guidelines (AFIF 291, 30 min)
16mm Film, The Other Guy (FLC 15-0078 & 79, 54 min)
35mm Slides, Counseling Techniques
Slide/Sound, Presentation, Clarifying your Values-Guidelines for Living (Part I&II)
Slide Sound, What the World Needs Now
Videotapes, Blank
Book, Alternatives to Drug Abuse/Steps Toward Prevention

Training Methods
Lecture (18) (1.5 hrs demonstration role-play uses 2 instructors in lecture mode.)
Discussion/Performance/Group (36)

Multiple Instructor Requirements
Supervision (2) (Total of 8 hrs dischargee counseling practicum)

Provide an introduction to individual and group counseling, with the emphasis on techniques and counselor and client attitude and responsibility. Describe effective counseling models and demonstrate their use. Stress client referral as an integral part of counseling. Use small groups for demonstration, clarification, and student practice.

Emphasize success factors and goals in alcoholism counseling. Carefully describe methods of breaking down the resistance of the alcoholic client. Stress the necessity for the alcoholic to assume personal responsibility for his/her drinking problem. Use role-playing to show, firsthand, the frustration an alcohol counselor can experience.

Stress the factors which shape a person's values. Show how individuals seek fulfillment of their basic needs, whether by normal means or by dysfunctional methods. Emphasize that "rightness" is a reinforced, learned value. Explain how to use a seven-step process in determining one's own value system. In a group setting perform values clarification exercise to strengthen presentation and permit students to clarify some of their values and those of their classmates. Conclude the lecture presentation with the sound/slide program, "What the World Needs Now."

Describe the viable alternatives approach to drug abuse prevention and rehabilitation, stressing its objectives, application, and utility. In small groups divide students into dyads and have each determine potential alternative pursuits for his/her partner. Evaluate performance using the Viable Alternatives Worksheet.

Provide role-playing counseling experience in small groups. Use CCTV for added feedback on an availability basis. Allow students to practice some situations, then to perform for evaluation. Have students reverse roles as counselors and counselees. Evaluate performance. Arrange for actual counseling sessions in the evening with the Personnel Processing Squadron. Divide the students into appropriate groups and schedule them, under supervision, to perform in this live environment. Evaluate their overall performance.

MIR: Students are conducting live counseling sessions. Close supervision by qualified counselors is critical. No more than four students can be properly supervised and evaluated by one instructor.

SPECIAL NOTE: On the days students participate in evening counseling activities, they will be excused from the counseling practicum (two hours) scheduled during normal classroom time.

3ALR73430B/30LR7361B/30ZR7364B-IV/1 GENERAL COUNSELING TECHNIQUES
(Individual)

PART II - TEACHING GUIDE

INTRODUCTION (10 Minutes)

ATTENTION

MOTIVATION

One of our primary missions is that of giving counsel and guidance to Air Force personnel. The next few hours will provide some of the basic tools necessary to accomplish that mission.

OVERVIEW

1. Cover the lesson objectives with the class.

2. Develop the lesson chronology.

   a. Explain the demonstration.

   b. Identify the major areas to be covered in the lecture.

TRANSITION

Let's begin by discussing the reasons people use drugs.

BODY (3 Hours 40 Minutes)

PRESENTATION

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APPLICATION

1. Solicit from each student reasons people use drugs.

2. List the reasons for drug abuse on the chalk board. Examples of causes are frustration, peer-group pressure, relaxation, parents, aphrodisiac, etc.

3. Demonstrate, in front of the class, hypothetical dialogues which reflect a person using drugs for the various reasons listed on the chalk board. Each mock-setting should represent a counseling session at the Social Actions office which has been directed by some authority. Your role is that of the drug user. For example: "I first started using drugs because I felt very frustrated with my job, etc., plus all my friends are using them . . . ."

4. Have students participate by taking the role of the counselor.

5. Have one student at a time counsel you, the drug user. Take different roles.

6. Continue with different students, saving about five or ten minutes at the end of the first hour for summary and closure.

PRESENTATION

1a. CRITERION OBJECTIVE: Identify the three basic principles which affect every counseling relationship.

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1030

3ALR73430B/30LR7361B/30ZR7364B-IV/1

1. Explain that counseling involves a basic understanding of people and their interaction with themselves and others.

2. Identify the three basic principles which affect every counseling relationship.

a. Counseling is more a matter of what one perceives than what is said or done.

b. Success in counseling depends more upon the personal qualities in the counselor than upon the correct use of specific techniques.

c. Every interview is a unique experience because of the counselor's individual differences in how he/she acts and because of how the client responds. Counseling is an art more dependent upon shared experiences than on reported experiences.

PRESENTATION

1b. CRITERION OBJECTIVE: Identify the responsibility of the client in a counseling relationship, the goal of the counselor in Social Actions, and two counseling strategies that determine the necessity for counseling or conversation.

1. Explain that information is constantly flowing between the counselor and the client.

a. The client's information is primarily received through the perception of the counselor.

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(1) Verbally.

(2) Nonverbally.

(a) Emotions (anger, sadness, etc.).

(b) Body language.

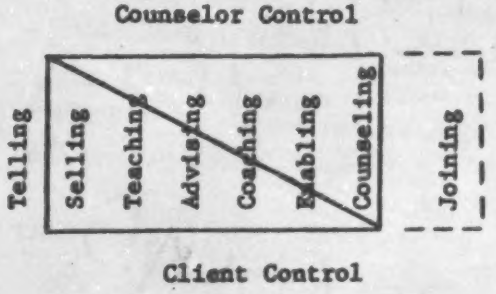
b. The information which a client gives a counselor is used as a resource for the client to use, rather than background for the counselor to use.

2. Emphasize that the client is responsible for his/her own growth.

a. The highest level of personal growth takes place in counseling due to the reflection of the client's information back to the client from the counselor.

b. The counselor is the sounding board or reflector for the client.

3. Explain that on a continuum of responsibility for growth, the highest level for client responsibility is in counseling. Discuss the continuum.



a. The lowest point on the continuum is telling. There is no responsibility for growth on either the client's or the counselor's part.

b. Selling is the beginning point for some responsibility for change.

c. As we progress through the continuum, the counselor's role is diminished and greater responsibility for action on the client's part is required.

d. Counseling, therefore, is an enabling role -- selling, teaching, advising, and coaching.

e. On the dotted line past counseling is joining.

(1) Joining a client in his/her problem takes power from the counselor; e.g., client asks, "Have you used mariuana?" Counselor says, "Yes.," to prove his/her friendliness and, therefore, rapport.

(2) The client needs a counselor in the most professional and ethical definition of the term, NOT A FRIEND. Remember, counseling not conversation.

4. Explain the role of the counselor as it applies to the Social Actions setting.

a. Counseling is not requiring the client to change, but rather to deal with (enable) the realities as they exist in the "here-and-now." Some changes will

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probably take place in the process of acting on the situation. However, our role in Social Actions is not to change a person, but to allow him/her to cope successfully with the realities as they exist.

b. The primary goal of therapy is client change. We are not therapists, unless qualified and certified to be so. If therapy is required, REFER.

5. Explain that by knowing the continuum for client responsibility, we can determine our need for conversation or counseling by the use of two strategies.

a. Interest strategy.

(1) This strategy provides for the most visible success for the client.

(2) Perception plays an important role here. The question to ask is, "Where on the continuum do I need to enter to gain quick success in dealing with his/her problem?"

(3) Counseling, as seen on the continuum, is obviously not necessary or possible in many sessions with clients.

b. Exit strategy. The counselor must eventually leave the client to act on his/her decision to grow (solve his/her problem).

(1) The counselor needs to ask him/herself, "What am I going to leave behind when exiting from the counseling session?"

(2) Leave the client at least as well off as he/she started (hopefully better).

(3) Perception and client's information will play a major role in determining the optimum time for the exit strategy.

APPLICATION/EVALUATION

1. What are the three basic principles which affect every counseling relationship?

2. What is the client's responsibility in a counseling relationship?

3. What is the goal of counseling in Social Actions?

4. What are two counseling strategies which determine the need for conversation or counseling?

PRESENTATION

1c. CRITERION OBJECTIVE: Identify the Four Rs of counseling and a definition of or a descriptive statement about each.

1. Identify the Four Rs in counseling (rapport, respect, risk, and relationship).

2. Discuss rapport. Rapport involves acceptance, understanding, and listening on the part of both the counselor and the client.

a. Acceptance of the client's right to be him/herself and all

that goes into making him/her; acceptance of the client's right to say anything he/she wants to say. Acceptance does not mean agreement with a person. It only implies the counselor's acceptance of his/her right to say it or his/her value system.

b. Understanding means to show the client that you are clearly on the same "wave length" and that you are actively listening to him/her.

(1) Understanding is shown to the client by such nonverbals as a head shake, "hmms," etc.

(2) Understanding does not mean agreement with the client, but only that you are aware of his/her statements.

c. Listening means that you are taking in all the information the client is giving you.

(1) Listening involves three areas: eyes, ears, and speech. My eyes are seeing your nonverbal and emotional messages. My ears are listening to your verbal messages, and my speech is reflecting your information back to you.

(2) Explain the "arc of distortion."

3. Discuss respect, the second of the Four Rs of counseling.

a. Respect involves the counselor's respect for the client's

person, values, etc., without placing the counselor's own values on the client.

b. Respect must also be from the client to the counselor for a productive counseling relationship to take place.

4. Discuss risk, the third of the Four Rs of counseling.

a. Risk implies that rapport and respect are present.

b. Since we know that the third basic principle of counseling is that each interview is unique, the uniqueness comes from the risk-taking efforts of both the counselor and the client.

c. Uniqueness means that we don't know how the client will react to our statements or actions, in order for us to implement the exit strategy.

5. Discuss the counseling relationship, the last of the Four Rs of counseling.

a. There can be no relationship without the accomplishment of the first three of the Four Rs. The first three are dependent upon the second basic principle of counseling; i.e., the counselor's personality, warmth, and responsiveness to the client.

b. Crucial to the relationship is that the client must establish his/her relationship with the counselor by the establishment of the first three Rs.

c. If there is no relationship, no counseling takes place.

PRESENTATION

1d. CRITERION OBJECTIVE: Identify the three major activities that take place in a counseling relationship and a definition of or a descriptive statement about each.

1. Identify the three major activities in counseling relationships, transference, countertransference, and coping mechanisms.

2. Explain transference. The client attributes to the counselor expectations, hopes, needs, etc., of the major figure in his/her life; e.g., mother, father, girl friend, "it," etc.

a. If transference is not cleared up and the roles of the client and counselor are left in this state, counseling cannot exist, since the client does not perceive that the counselor <u>is</u> the counselor.

b. A useful technique to find out if transference has taken place is to ask the question, "What did you expect to find when you first came here?" This question will allow the client the latitude to state whom he/she thought might be doing the counseling; e.g., the client says, "I thought you would be just like my father, always preaching to me."

c. Never role-play with a client, using yourself as the figure. The counselor may stop

the role-playing. But, the client may still perceive him/her as the figure.

(1) If the client needs to deal with a figure in his/her life, use an inanimate object, such as a chair.

(2) The inanimate object allows the counselor to put the object away (out of sight) and the roles of the counselor and the client remain intact.

3. Discuss countertranference. This occurs when the counselor treats the client as the major figure in the client's life treated him/her.

a. An example is the transference of the role of "it" onto the counselor. If the role is not cleared up, the counselor will subconsciously act toward the client the way the counselor's "it" treated him/her.

b. Countertransference presumes the second basic principle of counseling; i.e., understand yourself and the need to clear up the transference quickly.

4. Discuss coping mechanisms.

a. Coping mechanisms are employed by all people. Examples include denial, rationalization, projection, rejection/acceptance, regression, fantasy, anger, aggression, hostility, compensation, withdrawal, and silence.

b. In counseling, we are dealing with the excessive use of

coping mechanisms by the client. Our role as counselors is to enable the client to deal with the reality of his/her situation, and not rely on the excessive use of coping mechanisms.

c. The coping mechanism of withdrawal produces the two noticeable effects of sadness and depression. This coping mechanism is seen more often than most. Be aware that it is withdrawal which you must deal with, not sadness or depression.

d. The most disturbing coping mechanism for the counselor is silence, productive or nonproductive. Perception is greatly needed to determine which category you are dealing with.

(1) Productive silence is usually a thinking state which allows the client time to deal with the information.

(2) Nonproductive silence is usually noticed by the counselor through the nonverbals of eye contact, folded arms (as in defiance), etc.

(3) Productive silence is best left alone until the client is willing to break it. If it is too much for the counselor, he/she might ask, "Would you mind sharing your thoughts with me?"

(4) Nonproductive silence can best be dealt with by reflecting the obvious language coming at you. For example, "I see that something has made

you angry and upset." In this way, the counselor is dealing with the verbal, nonverbal, and emotional language of the client.

PRESENTATION

1e. CRITERION OBJECTIVE: Identify three basic counselor approaches to a counseling session and a definition of or a descriptive statement about each.

1. Identify three basic counselor approaches to a counseling session, client-centered, counselor-centered, and eclectic.

2. Explain that information is passing constantly between client and counselor. How the information is given and received has a great deal to do with the establishment and maintenance of the counseling relationship.

3. Discuss the three basic counselor approaches to a counseling session.

a. Client-centered. The client is responsible for the growth he/she wants to have.

(1) The client does most of the talking in this approach.

(2) Nondirective counseling is another name for this approach. The counselor is not taking the responsibility for the client's growth.

b. Counselor-centered. The counselor takes more of the

responsibility for the client's growth.

(1) The counselor does most of the talking.

(2) Directive counseling is another name for this approach. The counselor directs the client.

c. Eclectic. This is a combination of both approaches.

EVALUATION

1. Identify the Four Rs of counseling.

2. What does acceptance mean with respect to rapport in a counseling session?

3. What is transference?

4. What is the most common coping mechanism?

5. What is the most disturbing of the coping mechanisms?

6. What is productive silence?

7. What is an eclectic counseling approach?

PRESENTATION

1f. CRITERION OBJECTIVE: Identify the four major types of questions used during counseling sessions.

1. Explain that in counseling the needs of the counselor must also be met, in order to have a successful relationship.

a. The counselor's needs affect the counseling relationship; for example, the need to be close, the need to dominate, the need to label, the need to use the third person, the need to be curious, the need to succeed, etc.

b. The need to label involves dangerous territory when attaching mental-health terminology without proper credentials.

c. The need to be curious -- when a counselor has an excessive need-to-know in areas of "tantilization voyeurism." Guard against it.

d. The need to succeed is inherent in all counselors. Proper questioning techniques will insure a better-than-average chance in counseling. The way to get a client to deal with reality is to provide a setting and questions which will facilitate his/her growth.

2. Explain the four types of questions used in the counseling session.

a. "How," "what," and "when" questions.

(1) Allows the client to deal with the "here-and-now," rather than the "there-and-then."

(2) Helps the counselor eliminate the need for third persons, since it is extremely difficult to incorporate third parties into personal, reflective questions.

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b. "Why" questions.

(1) These questions are good for gathering initial data.

(2) Their usefulness is limited to data collection.

(3) Usually receive a response of, "Because . . . ."

(4) Counselors should avoid this type question, whenever possible, as it does not reflect information back to the client.

PRESENTATION

lg. CRITERION OBJECTIVE: Identify six basic steps that a counselor should follow in any counseling session.

1. Discuss steps one, two, and three.

a. Establish the counseling relationship.

(1) If nothing else is done during the initial session, this step must be accomplished.

(2) This integrally involves the Four Rs of counseling.

b. Open psychological realities which may exist.

(1) If there are none, don't create any.

(2) Only open what your time and ability will allow you to close.

(3) Know your capabilities, so that you leave the client at least as well off as you found him/her.

(4) If there are more avenues opened than you can handle, REFER.

c. Establish a contract.

(1) This allows the client to take ownership of the sessions.

(2) Can be eliminated, if time does not permit.

(3) Be aware of the word, "contract." It is legal-sounding and may cause anxiety in the client. A better term is "agreement."

2. Explain that if the counselor had to eliminate any of the aforementioned three steps, he/she would eliminate the contract in favor of the relationship and psychological realities. If time was still critical, he/she would eliminate the psychological realities.

3. Discuss steps four, five, and six.

a. State a time limit. If one is not established, the client may open more problems than you have time to close. This is not fair to the client, and weakens the relationship.

b. Identify the specific problem.

(1) This step involves interest strategy.

(2) Counseling may not be called for, but advising may.

(3) This allows for a feeling of visible success for the client and the counselor.

(4) The type of question to ascertain immediate goal-setting after problem-identification is, "How will I know you are beginning to work on it?"

c. Summarize.

(1) This is best done by the client, if possible. The client will remember items which are important to him/her, if he/she summarizes. This is important to remember.

(2) Document all counseling sessions.

(a) Write down points which another counselor would need to know about the case, if you were unable to handle it again.

(b) Never tape a session without the client's permission. This is just professional ethics.

(3) Documents are not confidential; therefore, don't fall victim to your need to label.

(a) Counselors do not have confidentiality in that both you and your records may go to court, if ordered to do so.

(b) Privileged communication in the Air Force exists

in only three areas -- lawyer-client relationship, confessor-penetant relationship, and husband-wife relationship.

4. Explain that there are things to remember about your job as counselors and Social Actions personnel.

a. Counselors are human, not "machines."

(1) When counseling a client, many of our own memories of situations the client is mentioning are recalled. Be aware that many personal memories will be aroused within you.

(2) Never program a full day of counseling sessions.

b. Have weekly staff meetings with other counselors in your office.

(1) These are good for feedback on your techniques.

(2) They will alert you to "burnout."

(3) They provide good in-house training.

EVALUATION

1. If forced to eliminate either the contract, relationship, or psychological realities step in a counseling session, which one would you choose?

2. What is the most important step in a counseling session?

3. Why is documentation of counseling sessions important?

4. How are weekly staff meetings helpful to you as a counselor and as a person?

CONCLUSION (10 Minutes)

SUMMARY

1. Counseling mainly involves perceptions.

a. No book can teach perception.

b. No book can give you warmth, responsiveness, understanding, etc.

c. Technique will increase your awareness but will not, in and of itself, insure success in counseling.

(1) Success depends on the use of a variety of techniques, and also on being a warm, responsive, and caring person.

(2) If you feel that counseling is not your "cup of tea," do the client a favor, and stay far away from it.

(3) Some people are born counselors. Others, with a little information and practice, become counselors. Still others will never be counselors.

(4) KNOW YOUR LIMITATIONS AND CAPABILITIES.

(5) REMEMBER THAT YOU ARE NOT THERAPISTS.

2. The counseling relationship is the most crucial aspect of counseling.

a. Know the Four Rs.

b. Know your needs and those of your client.

c. Be aware of transference, countertransference, and coping mechanisms.

d. Know the six steps to a counseling session. Use them.

REMOTIVATION/CLOSURE

1. Counseling serves as the main area in which Social Actions personnel assist Air Force members with drug/alcohol problems to either return to productive duty or aid them with their transition back to civilian life.

2. Solid counseling techniques are necessary to success in your chosen job. They will permit your personal growth and, therefore, professional growth in your Social Actions speciality and in the Air Force.

3. Thank you for your attention.

ASSIGNMENT

Give complementary technical training assignment, when appropriate.

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STUDY GUIDE

3ALR734308/30LR7361B/30ZR7364B-III-1-1

Technical Training

Drug and Alcohol Abuse Control

Counseling Techniques

PART I - INDIVIDUAL

1 August 1978

HEADQUARTERS 3250 TECHNICAL TRAINING WING (ATC)
(USAF Technical Training School)
Lackland Air Force Base, Texas 78236

Designed for ATC Course Use

DO NOT USE ON THE JOB

1050

Social Actions Training Branch
Lackland Air Force Base, Texas

SG 3ALR73430B/3OLR7361B/
3OZR7364B—III-1-1
1 August 1978

Counseling Techniques

PART I - INDIVIDUAL

OBJECTIVE

Identify the basic principles of individual counseling.

INTRODUCTION

Effective counseling must have a foundation based on specific principles. It is important that a counselor understand these basic principles and how they affect the counseling relationship before moving into the application of counseling techniques.

INFORMATION

PRINCIPLES THAT AFFECT COUNSELING RELATIONSHIPS

Principle 1

The first basic principle of counseling is that counseling is more a matter of what one perceives than what is said or done. An example of this principle is: Person 1 says the word "hello" to person 2; person 2 *wonders* what person 1 wants. In this example, the important thing is not the word, but rather the perception person 2 is forming of what person 1 is doing. *"Perception" is the key word here.* Perception involves observation and awareness. An example of how these factors are involved in perception is illustrated by the following situation:

A client may relate his problem with alcohol as, "My wife is leaving me because she says I drink too much." As counselors we hear words; observe the behavior of the client during the session; and are aware of the tone of voice, body posture, etc. Through perception we, as counselors, must "hear" what the client is not verbalizing. We must hear the meaning behind the mere words. Thus, we are trying to understand the other side of the client's alcohol problem with a statement such as, "I'm aware you said your wife thinks you are drinking too much. From the expression on your face, you appear depressed." Thus, through perception, the counselor was able to see beyond the mere words into the nonverbal communication sent by the client. Summing the counselor's awareness and observations gave the client a chance to respond to the counselor's perception. Checking out your perceptions as the counselor allows the client to see himself/herself in the "mirror" which, you, the counselor, hold up to the client's combined verbal and nonverbal

behavior. The words are the medium used to relate your perceptions to the client. It is far more important to share your perceptions of the clients' behavior than merely repeat the words they are saying.

Principle II

The second basic principle of counseling is that success in counseling depends more upon the counselor's personal qualities than upon the correct use of any specific technique. Counselors continuously are updating their repertoires of possible techniques to use in counseling sessions in order to facilitate client responsibility. Success, however, comes from beyond the mere application of the techniques. Success comes from the counselor's genuineness, warmth, responsiveness, and concern for the client. If the counselor is perceived by the client as a noncaring individual, merely "filling the squares" on an 8—5 job, then all the techniques will be of little or no value to the client's rehabilitation. Many graduate schools rely heavily on this basic principle when training counselors in their counseling programs. Their basic rule is that some people are excellent counselors when provided the necessary methods of application in the counseling arts, and some people should never be counselors. The crux of this last statement is that some individuals, no matter what their desires are to help, cannot communicate caring, responsiveness, concern, etc. Counseling is not memorization and application of techniques but, rather, is a caring art.

Principle III

The third basic principle of counseling is that every counseling session is a unique experience due to the individuality of the counselor and the client. It is, thus, impossible to *predict* what will happen in any one counseling session. The counselor's and client's needs, personalities, backgrounds, perceptions, and concerns contribute to the uniqueness of the counseling relationship. It is thus impossible to re-create a counseling session with precise exactness since the time, mood, feelings, behaviors, etc., can never exactly be replayed. Only the outline of events can be reproduced. For example: A client was sitting in chair X; counselor in chair Y; counselor said the following words; client responded the following way. Thus, each counseling session is unique due to a variety of internal factors that cannot be exactly reproduced. This basic principle clearly identifies the importance of individuality within the counseling relationship. Counseling is an art dependent more upon *shared* experiences than upon *reported* experiences.

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CLIENT'S RESPONSIBILITY, THE GOAL, AND TWO STRATEGIES IN COUNSELING

Responsibility of Client

The highest level of personal growth takes place in counseling due to the reflection of the client's information back to the client from the counselor. This sharing of perceptions, feelings and thoughts between the counselor and client allows the client to look at himself/herself squarely in a "mirror" figuratively held up by the counselor for the client. Without this sharing, counseling ceases to exist since all information is only flowing in one direction (usually from the client to the counselor). The information, therefore, must be used as a resource for the client to use in his/her personal growth rather than as background for the counselor to keep and never share with the client. The key to counseling is to keep the responsibility for growth with the client. Sharing (reflecting) the client's information through the counselor's perceptions (Principle 1) facilitates the accomplishment of this key point in counseling. The client must be responsible for his/her own growth.

Goal of Social Actions Counselor

Our role, as Social Actions counselors, is to help the clients cope successfully with their realities as they exist. If the client's reality is the following: "Smoking marijuana is okay and the Air Force's reality is archaic," that is the client's reality. The problem here is that the client's reality and the Air Force's reality clash severely. The client does not have to change. However, if clients are to be kept responsible for their growth, clients must make a choice regarding which of the two realities they wish to keep. Thus, in enabling clients to deal with their realities, we are not sacrificing the Social Actions counselor's realities. The Social Actions counselor's goal is not to change the person, but rather to help that person deal with the reality as it exists.

Strategies

There are two strategies which the counselor needs to be continuously aware of. They are the Interest strategy and Exit strategy.

INTEREST STRATEGY. The interest strategy provides us, the counselors, with the most visible success. The client, as well as the counselor, has certain needs to be fulfilled when

entering a counseling relationship. Counselors must remember this so as not to have their needs interfering with the counseling relationship. The client's needs involve selling, teaching, advising, and counseling. The counselor, after listening to a client's concern may decide that the area of *interest* for the client to experience success is that of selling the client on the advantages of a viable alternative to their drug abuse; or of teaching a client about the physiological effects of alcohol on the body; or of advising the client of the Limited Privileged Communication Program; or of coaching a client on a new way of solving his or her behavior problems; or of counseling (enabling) the clients to successfully cope with their realities as they exist. Thus, the Interest strategy aids the counselor in determining in what area the client's needs will be satisfactorily fulfilled, thus allowing for immediate success for the client. The Interest strategy states that counselors should identify what the client needs and how to help the client meet this need as soon as possible.

EXIT STRATEGY. The second strategy is the Exit strategy. The bottom line message to the counselor and client is that eventually the counseling relationship *must* end. We in Social Actions primarily deal with short-term counseling. If long-term counseling or therapy is indicated, then we must refer the client to the agency which will provide that service for the person. The Exit strategy presupposes that we know what our capabilities and limitations are as counselors. This presupposition is necessary since we should leave clients at least as well off as we found them. If the client is a child abuser and the counselor is not empathetic towards this client, more harm than good can be done by continuing in this relationship. The counselor would lose no power in referring that client to another counselor, who would not be defensive with such a client. Awareness of our capabilities and limitations is a must for counselors.

THE FOUR R's OF COUNSELING

Rapport

Rapport is a term that is often misunderstood in the counseling relationship. Often, this term is used by the counselor to mean, "Don't upset the client"; "Feel comfortable"; "Get

your point across." Rapport is one term which encompasses three concepts. The three concepts are acceptance, understanding, and listening. An analysis of these three concepts will provide us with a workable definition of rapport.

ACCEPTANCE. Acceptance implies the counselor's willingness to allow the clients to be themselves without demanding change before the counselor will relate with them. Acceptance does not mean, however, that the counselor must *agree* with clients. A counselor can accept a person who is abusing a drug or alcohol *without agreeing* to the abuse of the drug.

UNDERSTANDING. The second concept involved in the definition of rapport is understanding. Understanding means that the counselor relates to the client, either verbally or nonverbally, that he/she is on the same "wave length" as the client. Thus, the counselor indicates to the client that he or she is *actively* listening to the client. Understanding is shown nonverbally by the shaking of the head up and down. Verbally, understanding is given by either asking the clients what they mean by a term, or by "uh-huh." The following example illustrates this concept: When a client tells you, the counselor, that he/she is an alcoholic, you have one definition of an alcoholic, and the client may have a different one. You will not know the client's definition of an alcoholic unless you ask. When you ask the client to give the definition of an alcoholic, you prevent a possible distortion of information. Rephrasing what the client says in your own words can also assist you in preventing perceptual distortions. Using these actions to prevent distortions will save you hours of miscommunication and the time necessary to correct them.

LISTENING. The last concept involved in rapport is listening. Listening involves not only our ears, but also our eyes and speech. Our ears will hear verbal messages. Our eyes "listen" to the nonverbal messages. Our speech "listens" to the client by checking out the data picked up by our eyes and ears. Counselors must check out the verbal and nonverbal data to gain a correct understanding of their perceptions. A caution to constantly keep in mind in dealing with rapport is *not* to confuse the term "empathy" with "sympathy." They are not synonomous, and are often misunderstood in the client/counselor relationship. Empathy means that the counselor borrows a client's feelings and psychological makeup in order to understand them, and to assist the client to clarify these issues. Empathy implies that the counselor still maintains his/her own separate identity. For example: When the client is continuously expressing concern over his/her career status, empathetically the counselor reflects the feelings and thoughts back to client. "You sound very concerned over your career and appear anxious over this issue." In this example, the counselor maintains a separate identity from the client while "borrowing" the client's feelings and thoughts in order to better understand the client's world. Sympathy means, however, that the counselor "takes on" the client's feelings and thoughts as his or her own, thus losing the separate identity and objectivity. The following is an example of sympathy in action: The client expresses depression over his or her spouse's leaving due to the client's alcohol abuse. The counselor, under the sympathy model, now appears to be as depressed as the client. The counselor under the sympathy model does not reflect the feelings and thoughts back to the client for the client's understanding. Instead, the counselor expresses the same emotion, agreeing with the client. The relationship then becomes "stuck" on this issue. In general, sympathy only perpetuates the client's feelings; whereas empathy helps the client understand and clarify his or her feelings.

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Respect

The second of the four "R's" is Respect. More easily said than done, respect involves the disengagement of the counselor's value system so as not to have the value system interfere with the counselor's listening, understanding, and acceptance of the client's value system. The counselor places the client's values on a scale to be weighed against the counselor's. For example: The client discloses that he physically abused his wife while under the influence of alcohol. The counselor who allows his or her value system to enter the session will condemn this action. On the other hand, the counselor who respects the client will deal with the client's feelings and thoughts regarding that incident, without imposing his or her value system on the client. The respecting counselor will also "stroke" the client for risking that kind of information in the counseling situation. Respect involves treating the client's thoughts and feelings as "hallowed ground" and not treating them with disdain or disrespect.

Risk

Risk is the third "R." For risk to take place in the counseling session, both rapport and respect must be present. The third principle of counseling is that each counseling session is unique and the uniqueness comes from the risk-taking efforts of *both* the counselor and the client. Risk involves two primary areas: confronting inconsistencies and the fact that anything can happen in a counseling session.

CONFRONTING INCONSISTENCIES. Confronting inconsistencies (incongruities) of verbal and nonverbal communication by the client is a risk the counselor takes to open the client's awareness. For example: The client relates a sad moment in his/her life and laughs. This inconsistency is then confronted by the counselor through a statement such as, "I have a hunch that that incident is not funny for you," or "Be aware that you just laughed after telling me what seems to be a sad moment." Confronting an inconsistency like this involves risk and must be undertaken gently.

ANYTHING CAN HAPPEN. The second primary area involved in risk is that counselors have no way of predicting what the reaction of the clients may be to their statements. Anything can happen in the counseling session. Using the previous example, the client could respond to the counselor's statement in a variety of ways: e.g., "You're right, it really isn't funny," or by silence, anger, leaving, or anything. The fact that anything can happen in a counseling session makes the risk of self-disclosure particularly frightening to clients. The client must build confidence in the counselor before he/she will be willing to risk disclosing more personal thoughts and feelings to the counselor. But in order to grow, risk must take place.

Relationship

The fourth "R" is Relationship. This "R" directly relates to the second principle of counseling: The counselor's personal qualities such as personality, warmth, and responsiveness. A successful counseling session is not possible without an effective relationship. Relationship does not mean that the counselor must be "Mr/Ms nice guy/gal." The concept does mean that the counselor has rapport, takes risks, and has respect in the ongoing counseling process. Relationship develops as a result of rapport, respect, and risk-taking. The four "R's" of

counseling do not work independently. They are interwoven through each session and over the entire period the counseling relationship exists. We have isolated the four "R's" here for educational purposes. Success in a counseling session depends not on the presence of these four "R's" but rather on the *effective use* of these "R's" by the counselor.

MAJOR ACTIVITIES OF A COUNSELING RELATIONSHIP

Transference

The first major activity which takes place in a counseling session is transference. This phenomenon occurs when the client attributes to the counselor the expectations, needs, hopes, and personality of a major figure in the client's life. The counselor is often seen not only as similar to the client's mother or father, but also sister, brother, wife or husband. Any "significant other" in the life of the client. If transference is not cleared up by the counselor, the counseling relationship ceases to exist because the client is no longer seeing the counselor as the counselor. The client will normally start relating to the counselor as he/she did his/her mother, father, etc. For example: A client enters your office and you state, "What did you expect to find when you first came here?" Client: "I thought you'd be preaching to me, *just like my father.*" The italicized part of this response is an indicator of transference. The client may continue to see you as the counselor and his/her father as long as the transference is not cleared up. One way to clear up transference is to deal with it directly. The counselor should state, "Do you see me as your father?" This allows the client to realize that you are the counselor, not the father. This maintains the counseling relationship and deemphasizes the father-son/father-daughter relationship.

Countertransference

Countertransference occurs when the counselor treats the client in the same manner as a major figure in the counselor's life. If the client's transference is not dealt with, the second major activity of counseling will occur: namely, countertransference. This phenomenon takes place outside the counselor's awareness. When countertransference occurs, the counselor begins to treat the client the way the client wants him/her to. The counselor will draw on a major figure in the counselor's life that fulfills the client's hidden agenda, and thus begins to act in ways similar to the way the counselor treated a major figure in his/her life. Using the example cited in transference, the counselor begins to "preach" to the client if transference is not cleared up. The counselor may have learned the "preaching" from his/her father, and may practice the "preaching" on his/her son or daughter. The counselor, however, may not have learned or practiced "preaching," and the counselor's father may have been a warm, caring individual who never "preached." The counselor may, in this case, draw from another figure in his/her life who did "preach," and use this person as a role-model from which to draw the behavior of "preaching" to satisfy the client's transference relationship. The client who gets the counselor to "preach" to him/her, therefore, receives the "payoff"; namely, the counseling relationship is now over, and the counselor is "preaching" to the client just as his/her parent-figure had done in the past. The counselor and client are now involved in a parent-child relationship which may perpetuate the original problem. The parent-child relationship does not foster dealing with the issues. It does foster the client living in the past. Awareness of the phenomena of transference and countertransference is the key to avoidance of this counterproductive relationship. Being active listeners will aid counselors to deal effectively with transference and countertransference, rather than avoiding dealing with them, and ending up in a nonproductive relationship.

Coping (Defense) Mechanisms

The third major activity that takes place in a counseling session is the use of coping (defense) mechanisms. Examples of coping mechanisms include, but are not limited to, the following: Denial, rationalization, projection, rejection, regression, fantasy, anger, aggression, hostility, compensation, withdrawal, and silence. All people have coping mechanisms. We employ them to survive in this often hostile world. All of us use at least some of these defense mechanisms at one time or another in our lives. We did this to "survive," "make it," "deal with reality," etc. Counseling is designed to deal with people who make excessive use of their coping mechanisms. These people make excessive use of coping mechanisms to the point that they distort reality, and their lives come to revolve around the coping mechanisms. Who determines what "excessive" use is? Society does. A person who constantly is withdrawn is considered to be exhibiting aberrant behavior. This person, most likely, is in need of professional help. In another society, his/her withdrawal may be considered as "normal." Thus, for the Social Actions counselor, coping mechanisms may present a problem when clients use them excessively. *If* the client is *strong enough* to deal with reality as it exists, then the counselor should confront the inconsistencies caused by the inaccurate perceptions.

BASIC APPROACHES TO COUNSELING

Counselor-Centered

The counselor-centered approach is also called directive counseling. The reason it is a directive is that the counselor is doing most of the decision-making, talking, and taking most of the responsibility for the client's growth. The hazard with this approach is obvious. If the client takes the counselor's advice and fails, the client can say to the counselor, "Look what *you made* me do." The client can blame the counselor, even if the client only tried half-heartedly. Despite the hazards of this approach, there are some situations in which you may choose to use directive counseling: Directive counseling takes much less time than nondirective counseling; thus, when your time is extremely limited, you may choose to use this method. Some types of clients may be so confused by their life situations that they need the counselor to intercede by "directing" order to their lives. There may be times when you need to "push" a client into detoxification. Generally speaking, however, it is better to allow your clients to make their own decisions about their lives, knowing they will have to live with the consequences of their decisions.

Client-Centered

Client-centered counseling assumes that within each person there is potential for a healthy personality. It is important in client-centered counseling for the counselor to have unconditional positive regard for the client, and that the counselor create a nonthreatening counseling environment. The client, in turn, must perceive this empathetic understanding. This environment helps the client develop the belief that the counselor respects him/her, will be kind, and understands how he/she thinks and feels. The counselor encourages the client to freely express his/her thoughts and feelings. Rather than being directive or interpretative, the counselor

accepts what the client is saying. The counselor responds by summarizing and reflecting back to the client what he/she has expressed. This helps the client clarify and formulate what he/she feels. As the counselor shows that he/she accepts the client's feelings and ideas without reservation, the client then starts to accept himself/herself. This self-acceptance and understanding is the key to unlocking insight which allows the client to consider all possible courses of action for solving problems. The self-acceptance allows clients to look at themselves and their situations without the defensive distortions of perception. Then the client gradually initiates positive action to solve his/her problems. In client-centered counseling, the emphasis is on the client making decisions and the client being responsible for what his/her life is like. The client is responsible for his/her own growth. One of the difficulties of this method is that it is very time-consuming, but it is often worth the time to change the self-image of the client so that the client can assume responsibility for his/her future life decisions.

Eclectic

The third approach is called the eclectic approach. Eclectic, in this sense, means to select a variety of approaches with no adherence to one to the exclusion of others. In counseling, the eclectic approach involves using not only the client-centered and counselor-centered approaches, but also other techniques. In eclectic counseling, the counselor selects the techniques that work; the ones that get through to the client best. In this technique the counselor may start by trying one technique, and if that one does not work, the counselor may select another in trial and error fashion. In eclectic counseling the counselor relies on his/her perception (Principle 1) and the use of the Interest Strategy to determine which technique will work best. The belief of the eclectic counselor is that nothing succeeds in counseling like success.

MAJOR TYPES OF QUESTIONS USED IN COUNSELING SESSIONS

"How, What," and "When" Questions

How, What, and When questions allow the client to deal with the "here-and-now" rather than the "there-and-then." These questions deal with the immediacy of the client's concern. These questions place legitimate demands for concreteness on the part of the client; e.g., "How is that a problem for you?" or "What is the significance of that act for you?" or "When are you going to change?" How, What, and When questions eliminate the need for third persons, and this is necessary since it is extremely difficult to incorporate third parties into personally reflective questions. By using these questions, the client is more likely to deal with the issues he/she needs to solve. By using How, What, and When questions, the dialogue with the client is more likely to be counseling than conversation.

"Why" Questions

Why questions, on the other hand, continuously remove the client from the immediate "here-and-now." *Why* questions allow clients to concentrate on the past "there-and-then" data. Examples of Why-type questions are seen when little children ask this question ad infinitum, ad nauseam; e.g.:

"Why is daddy going out?"

"Because . . . " is the usual response; e.g., "Because he needs to earn some money."

"Why does he need money?"

"Because . . . "

"Why . . . ?"

"Because . . . ," etc.

Why questions can be used by the counselor, however, to gather initial data from the client. But past the initial data-gathering stage, Why questions should be avoided. Why questions ask the client to defend "why" rather than examine the situation as it is in a nondefensive way. Counselors should avoid Why questions, except in the initial data-gathering phase of counseling.

Questioning Technique

Cautions to remember regarding counseling questioning techniques are: (1) Ask one question at a time, and (2) be sure to obtain the response you asked for in your question.

ONE QUESTION AT A TIME. If a counselor asks multiple questions to the client, the client can only respond to one at a time. If you ask two at once, you increase the

probability that one of the questions will not be responded to. For example: "What did your friends think of you when you said 'No' to smoking marijuana? And what did you feel when you chose to say 'No'?" These are two good questions; however, only one can be answered at a time. Limit your questions to one at a time, and then follow up with the other question after you have the first response.

OBTAIN RESPONSE ASKED FOR. The other caution when questioning is to be sure to get the proper response sought for in the question; e.g., "What did you feel when you said 'No' to your friends?" If the answer is "I felt like a real heel," this is not a proper response to your question because the question asked for a feeling, and a thought was given in its place. The clue to this substitution is the phrase "feels like" which usually depicts a thought. The counselor must confront that discrepancy by repeating the question; e.g., "I'm aware that you expressed a thought; what did you feel?" to which the client may respond, "I felt badly." This is a response to the question plus it clarifies the distinction of thoughts and feelings for the client. This technique clearly relates to the client the effective listening skills of the counselor (part of rapport). Another example which illustrates how well you need to listen and obtain the answer to your question is taken from a television tooth-paste commercial: The question is asked, "Jane Brown, stewardess, Pan Am, how is your love life?" Stewardess: "New York, Paris, Rome." Question: "Yes, but how is your love life?" Stewardess: "Rotten." Finally, the questioner has the proper response to the original question.

SIX STEPS OF A COUNSELING SESSION

Establish the Counseling Relationship

Of the six steps, this is the most important. Without a good counselor/client relationship any positive change in behavior by the client as a result of counseling is at random. The key to establishing a relationship is counselor involvement. The counselor must build

a firm emotional bond with the client. This may be the first experience the client has had in such involvement. The clients then experience a person with whom they can become emotionally involved, someone they can care about, and who they are convinced cares about them. Also, someone who can convince them that they will stay with them until they can better fulfill their needs. The ability for the counselor to establish a relationship is a major requirement. It often becomes a difficult task especially when the client does not want to be in counseling. Clients may resist because they have been disappointed too many times in the past when they attempted to find someone to become involved with. This resistance may also be a way of testing the sincerity and responsibility of the counselor. The counselor in the relationship must then be responsible, interested, human, sensitive and, when the situation warrants, tough.

Open Up As Many Psychological Realities As May Exist

Individuals who are abusing drugs or alcohol often do not realize the impact such behavior is having on other aspects of their lives. It is an important part of counseling for the counselor to open up such realities as they exist for the client. An example of this is a male member of the Air Force with 17 years' time in service who has thought alcohol abuse is not only tolerated, but is an accepted behavior. His experience has been to see alcohol glamorized; and becoming intoxicated has become a common occurrence which he thinks is part of fulfilling the airman image. Now, because he has experienced problems as a result of his drinking, he is a participant in the Air Force Alcohol Rehabilitation Program by order of his commander. This airman's first reaction may be to take the program lightheartedly, become angry, or be resistant. After becoming involved in counseling, what soon surfaces are the other aspects of his life that are being negatively affected by his alcohol abuse. These difficulties may range from his marital relationship to his job performance. A further reality may also be that he fears being discharged before retirement, despite his time in service. The role of the counselor is to bring into the awareness of the client those aspects of his life that have become painful. These are "hurt" points which have been avoided and may be totally out of the awareness of the client. This is where the counselor's perception becomes vital in sifting through what is being said and confronting the client's incongruent behavior. Counselors must be cautious not to exceed their counseling capabilities while bringing these painful issues into the clients' awareness. If the client needs intense psychological therapy, marriage counseling, or financial assistance, etc., the skill of the counselor becomes his/her ability to effectively refer the client. A good referral is more likely if the Social Actions Office has established a sound referral network. Another important aspect of opening up psychological realities is the counselor keeping mentally aware of time during the counseling session. The responsibility of the counselor is to open up only those realities for which there is adequate time for proper closure. The counselor's role is also making the clients aware of their responsibility not to wait until the last part of a counseling session (Example: 5 minutes remaining) to bring up critical issues that may be left unfinished because of lack of time.

Contract

The contract approach to counseling allows the client to take ownership for the changes that take place, or don't take place, because of counseling. Contracts are the part of counseling that specifically isolate a behavior that the client is not happy with and wants to change.

Counseling contracts should be regarded with as much respect as are legal contracts in courts of law. It is important that contracts are stated in specific, observable, behavioral terms. In the case of the alcohol or drug abuser, contracts might involve gaining control over drinking or drug use; this specific, observable change is a good basis for a counseling contract. As clients verbally express what they want from counseling the counselor should confront generalities. As an example of vague contract offers: better relationships, emotional maturity, responsibility, and self-understanding are not specific and should not be used.

Once a specific change of behavior is expressed there should be mutual consent. This means that, in order for a contract to satisfy the requirement of mutual consent, it is necessary that both parties be able to specify what they are consenting to. Occasionally, a client will request counseling for a condition which the counselor is not competent to work with, such as a marital problem. At this point, it is important that the counselor refer the client to a competent marriage counselor, or possibly a chaplain whom you, the counselor, know is good at marriage counseling.

State a Time Limit

The counselor should specifically tell the client how long the counseling session will last when they begin. This gives the client a reference point. It eliminates the uncertainty of the client, who may wonder, "Do I have time to tell what I did last night?" It also places additional responsibility on the client to take care of himself/herself, by getting out of counseling what he/she wants, rather than engaging in idle conversation. It is important to remember the behavior changes stated in the contract by the client entail the client experiencing emotionally painful issues. A normal client response might be to evade the pain by attempting to manipulate the counseling session. The client who continuously waits until the later stages of counseling before surfacing an important problem should immediately be confronted. When the client says, "What I really want to tell you is . . . " or "What I really want to say is . . . ," chances are, everything said before the statement has been an avoidance of the real issue. Also, if a time limit is not established, the client may disclose more problems than the counselor has time to adequately close. Time is an important responsibility issue for both the counselor and client.

Identify the Specific Problem

It is not uncommon for drug or alcohol abusers to not be aware what major problems exist in their lives. They may understand the immediate reason they are face-to-face with a Social Actions counselor — "My commander sent me." or "I got unlucky and was pulled over by the security police after I left the club." — but out of their awareness the real issue may not be consciously known. By the counselor confronting incongruent behavior and processing behavior patterns, clients may experience a new enlightenment. This may mean facing, for the first time, emotionally painful circumstances. An example may be an alcoholic confronting the fact that he/she cannot consume alcohol without becoming involved in some type of unacceptable social behavior. This is a painful and frightening experience. Identifying specific problems involves the counselor creating a situation that allows the client to organize his/her thoughts and feelings. The client, in a brief statement, may relate to the counselor several critical issues that are causing him or her emotional discomfort and,

in his or her emotional state, may not be clear about any one of the issues. An example is a male client who states to the counselor, "I'm really having problems. Everyone keeps nagging me. I go home and my wife isn't happy. She says I spend too much time with my friends. My kids say we fight, and they won't stay home. But I think the real problem is my boss. He's a slave driver that never lets up. I hate his guts. I'm confused. The only peace I have is with my friends at the club." This condensed example contains several issues that need separation and clarification. It is important for the counselor to identify specific problems as they exist for the client. A technique the counselor might employ is reflecting back to the client his statement:

Counselor: "I hear you dealing with several problems: your situation at home with your wife nagging you; your children saying you fight with your wife, and then leaving; your boss being a slave driver; and the only peace you have is being with your friends at the club."

Client: "Yea, you've got it."

Counselor: "Which one of these problems is the most pressing for you now?"

Now the counselor has separated critical issues and allows the client to deal with the issue which is creating the most discomfort for him. The counseling session now has direction and the client has taken his first step toward resolving his emotional pain. There may also exist the possibility that some clients only need factual information, such as who, where, and what the Area Defense Council does; education on the physical and psychological effects of drugs; or, any one of many referrals that exist on or off base. It is the responsibility of the counselor to determine the area of interest strategy that best fulfills the client's needs.

Summarize Session

Before terminating a counseling session, an important step is to summarize the significant issues discussed. If possible, the best approach is to have the client summarize. This allows the counselor to hear those aspects of the counseling session that were important to the client. It provides a time for last-minute clarification by the counselor. The client's summarizing also provides the counselor with feedback as to what was effective or non-productive for the client. The counselor can also use this time to give the client positive strokes for sharing these very personal and painful issues, and progressing to a better feeling state. Summarizing the counseling session is an excellent method for providing closure.

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STUDY GUIDE

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Technical Training

Drug and Alcohol Abuse Control

Counseling Techniques

PART II - TRANSACTIONAL ANALYSIS/GESTALT

26 June 1978

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26 June 1978

GENERAL COUNSELING TECHNIQUES

PART II - TRANSACTIONAL ANALYSIS/GESTALT

OBJECTIVE

Identify Transactional Analysis and Gestalt techniques shown to be useful in social actions training.

INTRODUCTION

Counseling is an art that requires such personal qualities as: sensitivity, empathy and a genuine concern for helping other human beings. But as in any art these inherent qualities are not enough. In counseling it is essential that counselors also have a sound understanding of the theories that explain human behavior. Understanding the theoretical concepts of behavior is then the first step to effective counseling. This objective will cover a theory called "Gestalt Psychology" and explain the basic premises upon which it is based. We will then examine the three basic principles of Gestalt counseling.

INFORMATION

APPLICATION OF TA/GESTALT TECHNIQUES TO THE USAF DRUG/ALCOHOL REHABILITATION

According to the Department of the Air Force, as stated in AFR 30-2; "The objective of the Air Force Rehabilitation Program is to return all identified Drug/Alcohol Abusers to full duty status when feasible by redirecting their behavior toward conformity with Air Force standards of conduct and performance, or to assist them in their transition to civilian life". Rehabilitation can be accomplished by trained drug/alcohol abuse control specialist through individual and group counseling sessions. These sessions are not intended to be therapy sessions but are motivational in nature, client progress interviews, information meetings, and situational problem-solving sessions. This type counseling is well within the capabilities of drug/alcohol abuse control specialists. It is the responsibility of the drug/alcohol abuse control managers (OIC, NCOIC) to insure that the counseling is being conducted properly." Now let's take a look at how Transactional Analysis, Gestalt Counseling and the combination of both apply to the drug/alcohol rehabilitation program.

Supersedes HO B-III-1-18, Part II, November 1976

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Transactional Analysis (TA)

In information meetings the counselor insures the client understands such information as: Air Force Drug/Alcohol Rehabilitation Program, applicable Air Force policy/regulations, and civil laws. The counselor, understanding TA, can effectively focus his/her information, appealing to the client's adult ego state. In situational problem-solving sessions, TA illustrates to clients how they may be creating problems outside of their awareness. Using TA concepts clients learn to solve problems, such as supervisor-worker relationships (TA games), inability to comply with AF standards (how is the client setting up the situation to get caught, or the necessity to abuse drugs and alcohol). The progress interview allows the clients to learn exactly where they are in relation to rehabilitation standards. The TA concept of counselors stroking clients (reinforcement of behaviors), is a powerful method for reinforcing desired rehabilitation progress.

Gestalt Counseling

Gestalt Counseling is another method for promoting change. Whereas TA primarily uses the thinking (cognitive) process, Gestalt centers on "affact", or the feeling aspect in counseling. Using Gestalt techniques, clients bring into their awareness feelings which may be counterproductive to a healthy existence. Gestalt techniques help the client recognize unpleasant chronic feelings. Gestalt helps the client take responsibility for these feelings. This is an important step in bringing about behavioral change. Remember, motivating the client toward positive behavioral changes is an absolute necessity for effective rehabilitation. Gestalt techniques can help you get to the feeling behind the motivation.

TA/Gestalt Counseling

The combination of TA and Gestalt counseling can be a very powerful technique for use in base-level rehabilitation. If you adapt these techniques to your personality and use them effectively, you will give clients the chance to examine themselves thoroughly, and thereby make appropriate decisions. If you do not use these techniques well, not much will happen with clients, and they may become bored. The TA and Gestalt techniques you will learn are methods for helping clients understand themselves so that they can make better decisions about how they want to live their lives. The decision about the way clients choose to live should always rest with the client, once the counselor has helped make the client aware of pertinent information on which to base the decision.

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DEFINITION OF GESTALT PSYCHOLOGY

Gestalt is a German word for which there is no exact English equivalent. Gestalt means "meaningful organized whole". Other synonyms include: structure, configuration, theme, and relationship.

PREMISES OF GESTALT PSYCHOLOGY

Organized Behavior

The basic premise of Gestalt Psychology is that human nature is organized into patterns or wholes. Human beings have thousands of needs on the physiological as well as the social level (psychological). The more intensely one feels these needs are essential to life, the more closely one identifies with the need, and the more closely one directs his or her behavior or activities toward satisfying these needs. Through satisfaction of these needs, persons develop patterns that they need to survive physically and exist socially in the world as they perceive it. A person is inseparable from his/her environment and must be understood in the context of the "need-satisfaction" process. To understand human behavior, you must look at the whole, the totality of persons and their environment in order to see the "need-satisfaction" process and thereby understand human behavior.

Need Satisfaction Pattern

Another basic premise is that to understand human behavior, you must look for the pattern which is caused by the "need-satisfaction" process. To understand human behavior, you must look at the whole, the totality of persons and their environment in order to see the "need-satisfaction" process and thereby understand human behavior.

PRINCIPLES OF GESTALT PSYCHOLOGY

There are three basic principles of Gestalt psychology: organized perception, unfinished business, and avoidance. Let's first look at Principle I.

Principle I: Organized Perception

People do not perceive things as unrelated parts, but organize the parts through a perceptual process, creating meaningful wholes. An example, perceptual process, is the following. A person walking out of the social actions building does not see merely blobs of color and movement. The person perceives cars, grass, trees, and movement as a unit. As a person looks at the parts of a differentiated field, invariably one part stands out in a distinctive way from the others. This aspect of perception is called figure (that part that stands out), and the rest of the person's perception is called ground. What is perceived as figure to many people largely depends on prior experiences and needs. Emotions, attitudes, and values may also be involved. Persons tend to see what they have seen before and what best fits with their current needs.)

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Another example of organized perception is as follows. Observe a female olympic skier on a down-hill run during an important qualifying race. As she starts her run, what immediately stands out (figure) is the first turn. She sees the white snow grooved out by previous skiers, the exact position of the pole, and the shadows as they accentuate the degree of drop-off. All this happens instantaneously as she quickly organizes her perceptions as her body responds with movement. What becomes figure (or the background) are the people watching the race, their cheering noises, and the scenery surrounding the ski run. There may also be instances where the spectators become figure to the skier, especially if the course suddenly is situated close to a retaining wall where people are standing.

Principle II: Unfinished Business

Unfinished business is behavior and emotional patterns (gestalts) which have not been completed. Unfinished business includes emotions and events which have been interrupted and are interfering with here-and-now behavior. This is the phenomenon which prevents people from staying in the here-and-now. Often people experience emotional problems existing in the present, and yet only a part of themselves is in the here-and-now dealing with the problem. The old themes come back again and again to interfere with present problem solution. For example, let's consider a male client who experiences fear when in social conversations. This fear is so threatening (painful) that he avoids most social involvement. It is not uncommon for him to spend entire weekends alone. His fear is the possibility of being rejected. He is tied to a childhood myth that directs his behavior in the here-and-now. This is one aspect of his life that is unfinished and out of his awareness. As a child, he was constantly told by his mother to be kind, respectful, and not to hurt anyone's feelings (be a good boy). She also showed him how to do it by not being involved with people. He still remembers his mother saying, "Don't cause trouble." The psychological message was loud and clear, "Don't be close." To become self-supportive and participate fully in the present as it is, he has to give up this contaminated guidance (unfinished business), or the myth that he is responsible to his mother for his present behavior. Another example of unfinished business is the person with his/her supervisor over something the supervisor said yesterday. The worker holds on to resentment about the incident and does not attend to what the supervisor says today because the worker is not in the here-and-now. Chances are the worker will be scolded again today for not attending. This may confirm the worker's idea that the supervisor hates him/her and confirm the supervisor's idea that the worker is a day-dreamer.

Principle III: Avoidance

Avoidance is the process of circumventing emotions which are expected to be painful in order to prevent that pain. Avoiding unfinished business is a way an individual keeps from experiencing the past issues which are perceived in the "now" as being unpleasant. By avoidance of unfinished business, the unexamined feelings magnify. The person spends great energies

avoiding dealing with the unfinished business. The anxiety and anger magnify when not examined (confronted, dealt with, etc.). The person may show the anxiety or anger openly, or may blot out feelings in general and become depressed. Avoidance leaves only a part of the person to deal with what is happening to him/her "now." It is a steady nagging of the past affecting the present; most of the time it is out of the client's awareness. The role of the counselor is to provide clients with experiences which challenge them to examine and take responsibility for their feelings. In order for clients to replace these hidden, unpleasant emotions with good feelings, and for them to change behavior, clients must fully experience the pain, anxiety, mourning, rage, etc., which they have not previously allowed in their awareness. For example, avoidance is not an uncommon behavior in drug/alcohol rehabilitation group counseling sessions. A client may avoid a painful emotion by asking questions. This form of avoidance is behavior that shifts the responsibility to the facilitator or another group member and allows the client to escape confronting the pain. Another form of avoidance is intellectualization. A group member who uses intellectualizing as a means of avoidance will spend group time explaining why he/she has a certain type of behavior. This explanation may appear to be very rational, sincere, and at the heart of the issue, but will always focus on there-and-then situations. The clients may also spend vast amounts of energy analyzing and figuring out why they got to where they are, and feel bad. The clients, rather than reporting out to the group their feelings (hurt, anger, depression, etc.), may use technical or clinical language to avoid their true, or gut-level, feelings.

STUDY REFERENCE

1. Four basic steps in the application of the Transactional Analysis (TA)/ Gestalt Counseling model.

   a. Drawing up a contract.

   b. Check feelings of client out frequently in an attempt to identify the racket(s).

   c. Identify the injunctions.

   d. Through the use of Gestalt techniques, allow the client to face, once again, that situation, and push for a redecision.

2. Four things to consider when preparing for a TA/Gestalt counseling session, and...

   a. Importance of beginning and ending the session on time.

   b. Use of a tape recorder to self-train and to emphasize "glossed-over" verbalizations or contradictions.

   c. Use of chalkboard.

   d. Need of sufficient chairs for every group member arranged so that all are in full view.

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3. Three methods used to gain contracts in the TA/Gestalt method of counseling.

   a. A commitment based on the answer to the question. "How will I be different at the termination of these group meetings?" constitutes a contract.

   b. A commitment based on the answer to the question, "what do I want from these meetings for me?" constitutes a contract.

   c. The use of a life script questionnaire on each member will result in a contract.

4. Correct application of 10 rules of counselor conduct in a TA/Gestalt counseling session.

   a. Need to promote "now" awareness.

   b. "Direct communication process."

   c. Discharge of responsibility by using the words "it" and "you".

   d. Listen closely to questions asked by clients not only as a means of gaining information but also to disguise a feeling or thought or to direct attention away from themselves.

   e. The fruitless venture of dealing with hypothetical situations or questions.

   f. Need to prevent "gunnysacking."

   g. Avoid rescuing or "bandaiding."

   h. Use one-on-one in a group.

   i. Important for group members to correctly differentiate between "thinking" and "feeling."

   j. The group members are responsible to remain on the subject and stay functional.

5. Seven "cop-out" words which would normally be confronted by a TA/Gestalt counselor.

   a. "Try"

   b. "Can't" is the supreme "cop-out"

   c. "Want"

   d. "Should" and "ought to"

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e. "Why"

f. "Maybe"

g. "But"

6. Eight techniques for exploring non-verbal behavior when using the TA/Gestalt counseling model.

   a. Have the client exaggerate his/her body talk.

   b. Have a client verbalize non-verbal behavior.

   c. Focus on signs with questions or mimicking.

   d. Focus on inappropriate smiles or laughter with feedback questions.

   e. Exaggerate inappropriate body language observed to provide feedback.

   f. Have the client repeat incongruent voice intonations loudly or play them back for him/her to hear.

   g. Confront eye movement by focusing on it with questions or observations.

   h. Deal with silence by "riding it out" and listening.

7. Gestalt Counseling concept of Top Dog/Under Dog and two techniques for dealing with clients who are experiencing inner struggles with self.

   a. Have the client be the "top dog" and criticize other members of the group, followed by their response.

   b. Use chair work, having the client do a dialogue with his/her "top dog" in one chair and "under dog" in the other.

   c. Top Dog/Under Dog = self-hasseling, self-division, inner parent-child conflict.

8. Three requirements for getting closure on resentment and an effective technique for closing past romances and deaths.

   a. Resentment:

      (1) "Dump" the resentment through chair work until the member feels finished.

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(2) Gain forgiveness, particularly when significant persons are involved.

(3) Get the client to the point of gratefulness.

b. Past romances, and deaths: Facilitate closure through chair work.

9. Two Gestalt techniques used in heightening client's awareness of self-responsibility.

a. Have the client add the words, "And I take responsibility for that" to each statement made.

b. "Playing the projection" involves having the member own his/her projection.

10. Two techniques for facilitating the trying of new behavior.

a. "Making the rounds" with the other group members.

b. "Playing the reverse" of the behavior, e.g., shy becomes extroverted.

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PART II - TECHING GUIDE

INTRODUCTION (5 Minutes)

ATTENTION

Most people seen in counseling don't want to change. They want to feel better about their problems. Unfortunately, that's a short-term cure. Today, we'll learn an effective counseling model which promotes change in clients.

OVERVIEW

1. Read the lesson objective to the class.

2. Develop the lesson chronology.

MOTIVATION

If you can do what we'll talk about today, you will be a very effective counselor.

BODY (1 Hour 50 Minutes)

PRESENTATION

1c. CRITERION OBJECTIVE: Identify principles and techniques of coping with Dreikurs classical misbehaviors when they occur in counseling sessions.

1. Differentiate between overt and covert messages.

a. Explain that overt is what is said or given.

(1) Freud's manifest content

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of dreams (what happened).

(2) Freud's lantent content of dreams (what symbols meant).

b. Explain that covert is what is meant or implied by the message.

c. Most meaning, or implied behavior, in an interpersonal transaction is covert; i.e., beyond the mere words which are spoken.

EVALUATION

1.. What is the difference between overt and covert messages?

2. Which form of behavior is the most common?

TRANSITION

2. Select the four basic premises of Dreikurs' model of misbehavior.

a. Explain Premise I. All behavior has a purpose.

(1) Purpose may be solely physiological.

(2) Purpose may be physiological/psychological.

b. Explain Premise II. The purpose of behavior is_____.

(1) Fill in blank according to needs of client.

(2) Don't assume you know what the purpose is without asking the client.

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c. Explain Premise III. Behavior

that is reinforced will be repeated. (Probability of repetition increases.)

d. Explain Premise IV. To change misbehavior, stop reinforcing the behavior.

(1) In Transactional Analysis (TA) terms, don't stroke people in their racket.

(2) When reinforcing stops, initially the behavior increases and then decreases.

EVALUATION

What are the four premises in the Dreikurs' model?

TRANSITION

3. Identify Dreikurs' four classical misbehaviors.

a. Define engagement and disengagement.

(1) Engagement is an attempt to control the response of the therapist.

(2) Disengagement is the therapist not being controlled.

b. Explain attention.

(1) Covert message is: "Pay attention to me."

(2) Receiver feels irritated.

(3) Disengage by not reinforcing.

c. Explain boss.

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(1) Common military misbehavior.

(2) Receiver feels angry or scared.

(3) Great power is not acting scared or fighting.

d. Explain counter-hurt.

(1) Power with a vengeance.

(2) Counselor feels guilty and hurt.

(3) Disengage by not being hurt.

e. Explain disabled.

(1) "Yes, but. . . ." Key to the game.

(2) Counselor feels frustrated and may give up.

(3) Disengage by naming the game, collapsing on the client or not giving up.

EVALUATION

1. What are the four classical misbehaviors?

2. What is the most common misbehavior seen in the military?

TRANSITION

4. Identify four steps to disengagement, using Beier's Model.

a. Identify Step I. Ask self: "What am I feeling? What's happening?"

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b. Identify Step II. How might this behavior serve the client's pathology? Develop hypothesis.

c. Identify Step III. How can I disengage?

(1) How could I feel differently?

(2) How could I respond differently?

d. Identify Step IV. Disengage.

(1) Does behavior change when I disengage?

(2) If behavior doesn't change, then probably not disengaged.

e. Give examples.

(1) Let's go to a drive-in.

(2) Have you ever taken dope?

(3) Oh, counselor, you're wonderful!

EVALUATION

What are four steps to disengagement?

APPLICATION

1. Role-play some problem clients, using this model: Tell students demonstration is not a time to play "stump the band," but a chance to act as a client and experience a changing relationship.

2. Tell students to be natural, and if they feel change, to go along with it.

3. Ask students to examine what is happening. If the instructor gets

"hooked" (engaged), see how he/she might get out of the engagement.

4. Solicit a problem from the class.

5. If no one volunteers, use role-playing of:

   a. The reluctant client.

   b. The angry client.

   c. The helpless client.

   d. The "seductive" client.

6. Accept volunteers at any point.

   a. Halt if student is not serious.

   b. Role-playing may get into students' own problems. Be prepared to quit at that point.

CONCLUSION (5 minutes)

SUMMARY

Discuss overt and covert behavior, a model of behavior, some classical misbehaviors, and how to disengage and not be controlled.

REMOTIVATION

Practice these skills. They will help you personally and, in turn, help your clients.

CLOSURE

Remember to stroke people. Stroke what you want; ignore what you don't want. This is powerful.

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STUDY GUIDE AND WORKBOOK

3ALR73430B/30LR7361B/30ZR7364B-III-1-18

Technical Training

Drug and Alcohol Abuse Control

GENERAL COUNSELING TECHNIQUES
PART III
DREIKURS AND BEIER - A RESPONSIBILITY MODEL

June 1977

HEADQUARTERS 3250 TECHNICAL TRAINING WING (ATC)
(USAF Technical Training School)
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Social Actions Training Branch
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SG 3ALR73430B/3OZR7361B/
3OZR7361B-III-1-18
November 1976

GENERAL COUNSELING TECHNIQUES
PART III

DREIKURS AND BEIER — A RESPONSIBILITY MODEL

OBJECTIVES

Differentiate between overt and covert messages.

INTRODUCTION

People have the need to see themselves in a good light coupled with the apprehensic that maybe they really aren't all that "good." This conflict of "Who I think I'd like to be?" versus "Who I'm afraid I am," needs resolution. One resolution of that conflict is to conceal my real self/intentions from others and even from me. There are a lot of theories about short term rehabilitation counseling. This happens to be a theory that works with real people who have problems in living.

INFORMATION

OVERT AND COVERT MESSAGES

Definition of Overt and Covert Messages

Clients often give messages designed to conceal rather than reveal their person and purpose. It is not as if the client has a deliberate plot to mislead or deceive the counselor. More often than not, this happens outside the clients awareness and the purpose is to maintain the clients self-deception. This deception works because the clients gives two messages at the same time.

OVERT MESSAGE. The first message is the overt message. The overt message is the words that are said, the mere words — the verbal content.

COVERT MESSAGE. The second message is the covert message. This is the meaning beyond the mere words; what is meant or implied that goes beyond the exact wording of the message. Covert messages usually carry an emotional content.

Examples: Have you ever had someone say, "See ya later" in such a way that you knew you'd never see them again? Another example is being told "Good Morning" in such a way that your gut-level reaction is "Same to ya." How about, "Would you like to come up to my apartment and see my etchings?" An example from counseling would be clients talking about their supervisor saying, "He doesn't bother me." with a harsh voice through clenched teeth. Much of the meaning from covert messages is affect (emotion) oriented. The covert message often deals with an emotion or a responsibility the

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client would rather not "own." Reread the example of the client talking about the supervisor. Suppose the client has some problems dealing with anger especially with authority figures. The client disowns anger by not being aware of the feeling, and makes a statement contrary to the emotional facts. But the covert message carries clearly through the medium of voice and clenched teeth. The vast majority of the meaning we get in our conversation comes from the covert messages. It is the covert message which gives us our first hints of love, anger, fear, and compassion. These feelings are conveyed to us by touch, voice tone, posture, or even contextual implication beyond the words spoken.

OBJECTIVE

Select the four basic premises of Dreikurs' model of misbehavior.

INTRODUCTION

One way of understanding desired behavior is to examine some basic premises of misbehavior and how to change misbehavior.

INFORMATION

DREIKURS' MODEL

Premise I

Premise I is, "All behavior has a purpose." No matter how weird or bizarre the behavior may appear, it is serving the client in some fashion. The purpose may be solely physiological; as regurgitating to relieve an upset stomach during a particularly vicious hangover. The purpose may be psychological as in talking so much that the counselor can't get in a word, thus preventing confrontation. The purpose may also be psychological/physiological as beating a chair to relieve anger feelings.

Premise II

Premise II states, "The purpose of behavior is _____." This is a fill in the blank statement. You can never be certain of how a particular behavior serves a client unless you ask the client. Some people go to work to have a good time. Others go to work to escape their families, and for some it is a place to go die. All the above mentioned people go to work. It takes good questioning and listening to detect a particular client's purpose in his/her behavior.

Premise III

Premise III is, "Behavior that is reinforced will be repeated." The probability of repetition increases if a behavior is reinforced. If you say, "Thank you for hugging me; I really like it." that will greatly increase the chances you'll get hugged again (probably right that moment). In fact, if you say it again coupled with, "You're really a great

hugger!" you may wind up staying there for an indefinite period of time. Not only will reinforcement increase the probability of getting what we want, but also what we don't want. For example: If someone who is angry comes in the office and you say, "Hey, turkey. What are you yammering about?" they will probably give you a good dose of anger. If you up the ante following that outburst by saying, "Hey, I didn't ask to get yelled at." you might even get a punch in the nose. In summary, if you want something bad enough to get it, stroking (reinforcing) the behaviors you want repeated, will help you.

Premise IV

The fourth premise is, "To change misbehavior, stop reinforcing the behavior." Implied in this is not only to stop reinforcing the behavior you don't want but to start reinforcing the behavior you *do* want. Reinforcing a "good" behavior that is incompatible with the misbehavior is just as important as not reinforcing the misbehavior. For example: The statement, "I really like it and listen better when you're speaking to me in this calm voice." reinforces a behavior (calm tone of voice) which is incompatible with the misbehavior (yelling). This concept is simple. The application requires considerable thought, however. The technique is very powerful.

OBJECTIVE

Identify Dreikurs' four classical misbehaviors and appropriate disengagements.

INTRODUCTION

We will examine four classical misbehaviors and then look at the possible disengagements from the misbehaviors.

INFORMATION

DREIKURS' CLASSICAL MISBEHAVIOR AND DISENGAGEMENTS

Misbehavior I

The first misbehavior is "attention" (refer to page 8). The person's overt message is, "Hi, how's everything going? Shrinking any heads today?" The covert message being, "Somebody please pay attention to me." This is a sneaky way to get some strokes. It was used rather than saying, "Hey, I need some attention." It was probably used because the person felt it was not okay or not acceptable for adults to ask for attention. The feeling of the receiver of the message is one of irritation; as if a small child wanting a drink of water only when you're on the phone. The expectation of the sender is that you'll pay attention to me even if it is to tell me to get the heck out of the office. Now that we've identified the misbehavior let's look at some ways the counselor can get "unhooked" or become disengaged.

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DISENGAGEMENT ONE. The first disengagement is pay no attention to the overt message, "Hi!" In our culture if you act like the wind is blowing when someone says, "Hello." They are likely to get highly offended. Not only might they be offended, but also bad mouth you all over the place. This makes the second disengagement preferable.

DISENGAGEMENT TWO. The second disengagement is to set up the situation so you can stroke the person for behaviors you want. For example: When they say, "Hi," you say, "Wow, am I glad to see you. I need some help in fixing or cleaning out the _____ _____(fill in the blank)." And then talk while they help you do your work. One of two things will happen. Either you get extra help around the place that you don't have to pay for other than idle chatter, or the person decides to go play elsewhere. Each way you win.

Misbehavior II

The second misbehavior is "Boss." This is the most common institutional, and therefore, military misbehavior. "Boss" begins with a, "Have you stopped beating your wife?" message that no matter how you answer you lose. For example: A seemingly innocent but angry question of, "Are you going to help me?" can be answered, by a "Yes" or "No." If you answer, "No" the client gets to stay mad. If you say, "Yes", the clients can then escalate their demands for help to an impossible height where we are sure to fail, and then the client gets to be angry again. The covert message is, "I'm angry at you." The expectation is that the receiver will decide to fight or run. This fight or run can be either physical or, more commonly, psychological. One way to run psychologically is by defending ourselves. For example: The client says, "Dammit, I want some help here!" and the counselor comes up with all kinds of reasons why they can't help; they're not responsible, etc. A fighting response to that statement would be, "Oh yeah, what have you done about it?" With either response, the client gets to stay angry and little is accomplished.

DISENGAGEMENT. The disengagement is to not fight and not run away. In Transactional Analysis (TA) terms, the way for the counselor to get into their adult. The counselor can get into their adult by asking questions of themselves like, "If I fight or get scared, how might that serve this client?" One answer to the above question might be, "As long as we fight or I run, the client doesn't have to change." When the counselor begins to see the "Boss" misbehavior as part of the client's larger game plan, the counselor can look at the threatening statement more objectively and not get hooked.

Misbehavior III

The third misbehavior is Counterhurt. This is like "Boss", a power game, but it is power with a vengeance. Parents sometimes get into this game with statements like, "If you really loved me, you wouldn't have . . . joined the Air Force; married him/her; moved away and left me, etc." Clients get into this with statements like, "Here I trusted you and look what happened." or "If it weren't for you, I'd be okay!" When counselors buy this package they feel hurt and guilty. The expectation is that the counselor will end up taking responsibility for the client's problems.

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DISENGAGEMENT. The disengagement is to not feel guilty and make statements like, "How might it be serving you in some fashion to make me responsible for your bad feelings." The basic issue for the counselor is putting responsibility back with the client where it belongs.

Misbehavior IV

In "disabled," the client brings in an ostensibly straight problem like, "I'm having this problem with my supervisor; will you help me?" Then as the counselor gives suggestions, the client responds with, "Yes . . . but . . .." followed by the circumstance that makes that an unworkable suggestion. The covert message being that the clients are powerless to change the situation and therefore not responsible for what is happening in their life. By getting hooked into, "Yes . . . but . . ." and the concomitant (accompanying) disablement, the counselor ends up feeling frustrated and often vaguely angry. The expectation is that the counselor will eventually join the client and give up on this hopeless problem.

DISENGAGEMENT ONE. The first way is to not give up and keep giving suggestions until the client takes one. Experience indicates that this method takes lots of energy. Clients generally come back indicating how hard they tried, but even that didn't work and you then start over again with new suggestions.

DISENGAGEMENT TWO. The second method is to "collapse" on the client. Collapsing on the client is done by agreeing that their problem is insolvable. If you are feeling particularly playful, you may even exagerate the problem and possible consequences. For example: A client statement might be, "I can't get along with my supervisor," followed by an explanation and helpless look. The counselor might respond with, "Gee, that is terrible; it sounds absolutely helpless to me. Looks as if you'll get kicked out of the service, etc." The client's general response is, "Well, it's not *THAT* bad." The counselor then follows with, "Well, it looks bad to me. What could you do to change what's happening?" Then confront unreasonable solutions like someone dying pretending the client has cancer and needs sympathy or any other nonfunctional solution.

DISENGAGEMENT THREE. The third method, the one preferred by the author, is to name the game. In this method, the counselor makes a few suggestions and gets, "Yes . . . but . . ." maneuvers. The counselor disengages by indicating what has been happening; i.e., the ostensible request for information, the counselor's suggestions, and the client's discount of the suggestions by the "Yes . . . but . . ." In this sense you, the counselor, are an observer of the "process" of the counseling relationship. The counselor then asks, "How might it be serving you in some fashion to have an insolvable problem." At first, clients generally profess having this problem serves them in no way, but as they get into their fantasies about how it might be serving, they come up with interesting answers. For example: The "problem with my supervisor" issue often yields answers such as "If we quit fighting, I might have to change and I'm scared about that." The above statements get to gut-level issues the resolution of which yields a much healthier client.

OBJECTIVE

Identify four steps to disengagement using Beier's Model.

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INTRODUCTION

Most of us become readily engaged or "hooked" into certain traps clients set often outside their awareness. The difficult thing about applying this model is recognizing that we are becoming engaged and finding a way to become disengaged.

INFORMATION

BEIER'S DISENGAGEMENT

Engagement/Disengagement

First, let's review the difference between an engagement and a disengagement. Then we can look at the four steps of disengagement.

ENGAGEMENT. An engagement is an attempt to control the response of the counselor. "Engagement" and "covert message" are often the same thing. So, like the covert message, the engagement is most often a control message out of the awareness of the client, and usually it has emotional content. For example, the statement, "I'm going to kill myself." is a very controlling message that powerfully limits most counselor's range of responses. The covert message is a powerful, "Somebody better take care of me." Most counselors will, appropriately, take up that duty, at least on a short term basis, until the clients are better able to take care of themselves.

DISENGAGEMENT. A disengagement is the counselor not being controlled. For example, if the counselor had knowledge that, "I'm going to kill myself." is another emotional blackmail ploy by their client, then the counselor might respond, "I see you're into blackmail with me again. What's that all about?" This would disengage from the suicide statement and get to the issue under it.

Step One For Disengagement: The first step in disengagement is for the counselors to be in touch with themselves. The counselors can get in touch with themselves by asking, "What am I feeling? What is happening to me? Do I generally want to tell people 'Same to ya!' when they say 'Afternoon, counselor'? Do I generally want to put my arm around people and say 'Poor baby, I'll take care of you'?"

Step Two. The second step is for the counselor to ask, "How might my feeling for thinking like this serve the client's pathology?" For example, "How might my wanting to punch the client in the mouth be serving the client in some fashion?" In asking this question, the counselor is automatically developing some hypothesis around the nature of the client-counselor relationship. If the tentative answer to the above question is, "As long as we fight the client won't have to go to work." then the next step is automatic.

Step Three. The third step is to ask "How can I disengage? How could I feel/respond differently?" In the above example, a disengagement might be to suggest to the client that they are very good at playing "Let's fight." Cite some examples of the provocative behavior (with appropriate appreciative chuckles), and ask, "How might our fighting be serving (the client) in some fashion?" In TA terms, asking this third question puts the counselors in their adult, a much better ego state to disengage from.

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Step Four. The fourth and last step is to disengage; to act differently. If the client's feeling state/behavior changes then the disengagement is successful. If the client's feeling state/behavior stays the same, then counselor and/or client are still hooked on some level. Go back to step two.

Summary

This study guide has given an effective model for short term rehabilitation counseling. It indicates how to recognize covert messages and a model of misbehavior. The last part of the SG states of four classical misbehaviors and explains a general model for disengagement. If you apply these principles you will help a lot of people.

SUMMARY CHART OF THE DREIKURS AND BEIER'S MODEL

		OVERT MESSAGE	COVERT MESSAGE	FEELING OF RECIPIENT (COUNSELOR)	EXPECTATION OF SENDER (CLIENT)	DISENGAGEMENT
1.	Attention	Hi!	Pay attention to me.	Irritated.	Pay attention.	1. Don't attend. 2. Stroke desirable behavior.
2.	Boss	What's going on here? or Is this any way to run a railroad.	I'm angry at you.	Scared or angry.	Recipient will either fight or run away.	Don't fight or be angry. Don't run away or be scared.
3.	Counter-hurt	It's your fault that I'm failing *or* If you really cared, You'd . . .	I'll make you feel as bad as I feel.	Hurt.	Recipient feels bad, takes responsibility.	Don't be hurt. Don't take responsibility.
4.	Disabled Client	Help me. Counselor gives suggestion. Client — Yes . . . but . . .	I'm helpless, powerless . . . not responsible.	Frustrated	Recipient gives up.	1. Don't give up. 2. Collapse. 3. Name the game (Disabled).

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PART II - TEACHING GUIDE

INTRODUCTION (10 Minutes)

ATTENTION

MOTIVATION

Explain the importance of applying students' knowledge of counseling to the alcohol abuser.

a. Increased emphasis on alcohol education and rehabilitation in the Air Force, because of the realization of how many Air Force members are affected.

b. The alcoholic employs a variety of defense mechanisms due to the nature of the condition.

c. Counseling alcoholics requires personal introspection as to our goals and objectives regarding the very nature of what an alcoholic is and what alcoholism is.

d. Understanding the role of the alcohol counselor allows for growth through change.

OVERVIEW

1. Cover the lesson objectives with the class.

2. Develop the lesson chronology.

a. Types of alcoholism.

b. Success requirements.

c. Goals and objectives in counseling.

d. Motivation and the alcoholic.

e. The resistant alcoholic.

f. Denial, constructive confrontation, and client responsibility.

NOTE: PAGE 1091 IS MISSING; HOWEVER ALL MATERIAL IS INCLUDED.

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PRESENTATION

2a CRITERION OBJECTIVE: Identify three basic requirements for success as a counselor in the field of alcohol abuse and alcoholism.

1. Reemphasize that in the role as counselors it is necessary to "enable" the client to deal with reality as the client knows it.

a. This requirement of "enabling" is predicated upon understanding the causes of and, thus, the attitudes involved in alcoholism.

(1) Some psychological causes of alcoholism are Freudian, Adlerian, personality, and transactional analysis (TA) theories.

(2) Some theoretical physiological causes of alcoholism are genetotrophic, genetic, and endocrine.

b. The question which must be answered under the principle of "enabling" is, "How does growth in the capacity for self-determination and responsibility occur?"

(1) Counseling (enabling) shows us that one does not cure irresponsibility or egocentricity by a direct attack, nor does one produce real self-determination by increasing the individual's guilt load.

(2) Cultural, moral, and educational attitudes affect the understanding of the alcoholic and alcoholism.

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(a) Culturally (Temperance Movement).

(b) Morally. The assumption is that by emphasizing the personal culpability of the alcoholic, it will make him/her responsible; i.e., more moral.

1. Direct attacks on irresponsibility and egocentricity only increase defenses and inaccessibility to the client.

2. Moral approach may change surface behavior; i.e., behaving more morally in accordance with the ethical code of culture.

3. Enabling demands the respect of the individual.

(c) Educationally ("Skid Row").

2. Explain that the second requirement is that since growth in the capacity for self-determination comes as a person feels less guilty, the counselee must be more able to accet self and surroundings.

a. There are two assumptions.

(1) People are what they are largely because of the basic character structure.

(2) People have a power to change (redecide). "I'm not OK, they're OK" (pre-alcoholic) is moved to "I'm OK, they're not OK" (alcoholic).

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b. Release from the cycle of guilt and compulsion makes self-determination possible.

(1) This release is possible under counseling through the principle of acceptance.

(a) Acceptance lowers the alcoholic's defenses and allows him/her to face the truth.

(b) Direct attacks on the alcoholic only increase his/her need to defend self.

(2) This release from the cycle of guilt and compulsion is also possible under the auspices of Alcoholics Anonymous (AA).

(a) AA give group acceptance and sickness conception.

(b) Putting the responsibility for the allergy to alcohol on the "sickness" and the responsibility for the change of personality pattern which has driven the individual to drink, allows him/her to lower personal defense mechanisms; i.e., allows for self-acceptance and responsibility.

(3) Culturally, we are taught that willpower/morality will allow us to change.

(a) If the alcohlic thinks his/her problem is a sickness, society puts on pressure for sick people to get treatment.

(b) Culturally, some counselors state, "I will help the

suffering alcoholic but punish the celebrant."

1. The search for pleasure is part of the addiction.

2. This is the pleasure -- anxiety process in the conditioning of the sickness.

3. If the presence of elements of self-gratification prevents a malady from being a true sickness, then all neuroses must be eliminated from the category of "sickness"; i.e., all neurotic "solutions" involve some satisfaction, however warped.

3. Explain that the counselor must possess a positive attitude toward alcohol abusers, alcoholics, and alcoholism. The third principle of counseling is that the counselor must do a lot of personal self-examination on the ethical problems of alcoholics.

a. Come up with a working hypothesis, based on thinking and feeling about the fundamental problems of freedom, determinism, and personal responsibility.

b. A counselor's relationship will be influenced by heartfelt beliefs concerning alcoholism.

c. On personal responsibility, "Society greases the slope down which the alcoholic slides."; i.e., the chaos of the world and confusion and conflict on drinking and drunkenness, the traumatic circumstances to which many children are

subjected, contribute to the sickness of society of which alcoholism is one manifestation.

d. The goal of psychological health is the enhancement of self-determination; i.e., the capacity of a self to achieve responsibility for itself.

(1) To the extent that a person is driven by inner compulsion, he/she is not self-determining; i.e., not able to be responsible.

(2) Heredity, environment, childhood-conditioning, and unconscious drives are factors which impinge on decision-making. The compulsive person is a victim of these factors if he/she is unable to arrange them for personal purposes.

EVALUATION

1. What are the five types of alcoholism?

2. Which type represents the episodic drinker?

3. Which type represents the habitual excessive drinker?

4. What are the three requirements for success as a counselor in the field of alcohol abuse and alcoholism?

PRESENTATION

2b CRITERION OBJECTIVE: Identify two major goals and four objectives in counseling the alcoholic.

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1. Explain that much of the lack of precision in counseling procedures is a result of the counselor's confusion about the goals, or the counselor's striving toward unrealistic goals.

a. The first major goal is to help the alcoholic grow toward full potential for personhood, constructive relationships, and productive living.

b. The second goal is helping the person achieve ongoing abstinence from the drug (alcohol).

(1) With the chronic alcoholic, more limited goals prove to be the only ones which are realistic or achievable; e.g., reduction in the number of "binges," days lost from work, driving while intoxicated (DWI) charges, etc.

(2) With alcoholism, any degree of improvement is valuable.

2. Identify the four objectives in counseling the alcoholic.

a. Subsumed under these goals (particularly the second one) are four operative objectives. These are seen as overlapping stages of treatment.

b. The objectives are to help the alcoholic:

(1) Accept the fact that his/her drinking is a problem with which he/she needs help.

(2) Obtain medical treatment.

(3) Interrupt the addictive cycle and keep it interrupted by learning to avoid the first drink.

(4) Achieve a resynthesis of the alcoholic's life without alcohol.

3. Explain that alcoholism is a complex condition; i.e., team effort is needed.

a. The minimum membership consists of the following:

(1) Physician.

(2) AA.

(3) Counselor.

(4) Alcoholic.

b. The counselor is the coordinator.

c. Referral is necessary.

(1) Referral for some counselors is another way of saying, "Let George do it."

(2) The danger of referral is that this may be interpreted by the alcoholic as rejection.

(3) "Letting George do it" allows the counselor to miss an opportunity to help the alcoholic in the unique ways he/she is capable.

(4) Referral must be seen as a sharing of responsibility, not as a shifting of it.

(5) Referral demands familiarity with available resources; e.g., AA, Alanon, Alateen, a physician who deals with alcoholics, psychotherapists, alcohol information centers, alcohol clinics, alcohol rehabilitation centers, halfway houses for alcoholics, etc.

EVALUATION

1. What are the two major goals in counseling the alcoholic?

2. What are the operative objectives in working with an alcoholic?

3. Why should referral be handled carefully?

PRESENTATION

2c CRITERION OBJECTIVE: Identify the difference between motivation and a lack of it in the alcohol abuser or the alcoholic and ten questions which will assist the counselor in determining the client's motivation.

1. Again emphasize that counseling is always a perception. The techniques should be seen as suggestive, rather than definitive.

a. During the first contact with an alcoholic client, it is essential to find out to what extent he/she is open to help and what kind of help is desired (perception).

b. The client's motivation must not be overlooked; otherwise, counseling is nonproductive.

2. Differentiate between motivation and a lack of motivation in the alcoholic.

a. Generally speaking, inadequate motivation is the result of the alcoholic's seeing alcohol as a solution. Then, the alcoholic wants help in avoiding the consequences of personal behavior or the crisis circumstances he/she feels confront him/her.

b. Motivation, adequate to successful treatment, is present when the alcoholic sees alcohol as one factor which contributes to personal problems.

(1) The alcoholic will have a desire to change personal behavior patterns.

(2) The alcoholic sees inner pain as a result of his/her use of alcohol.

c. The key question in determining the alcoholic's motivation is: Is the alcoholic able to admit that alcohol is giving him/her serious trouble and that he/she needs help in handling it?

3. Explain that the discovery of the nature of an alcoholic's motivation can be accomplished through a variety of questions in the first interview.

a. What does the alcoholic see as his/her problem?

b. From the alcoholic's point of view, is drinking a problem or a solution?

c. Does the alcoholic see drinking as a cause of personal problems or simply as a way of gaining relief from them?

d. Does the alcoholic feel a need for help from others (from the counselor)?

e. If the answer to the preceding question is, "Yes," what kind of help does the alcoholic want (pacify spouse, help to drink moderately, etc.)?

f. Why did the alcoholic seek help when he/she did?

g. Was the alcoholic threatened or "dragged" into coming by spouse?

h. Is there some special crisis which puts the alcoholic under acute pressure at the moment, but which will pass?

i. Is the alcoholic's primary motivation for coming external pressure or internal pressure?

j. Ask enough questions to gain a picture of the alcoholic's motivation for coming and the help expected.

PRESENTATION

2d CRITERION OBJECTIVE: Identify three guidelines employed in counseling the resistant alcoholic.

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1. Explain that the first major guideline for an alcohol counselor to remember is to accept the alcoholic's right not to accept help.

a. Implicit in this guideline is the counselor's need to succeed.

b. In some cases, the counselor's acceptance of the alcoholic's right and freedom not to accept help acutually is a dynamic factor in enabling the alcoholic to accept help. i.e., not "buying into" a possible "game."

2. Explain that the second guideline is the importance of discovering the point or points at which the client is hurting.

a. This is the time when help is most likely to be accepted.

b. "Hurt point(s)" can be found by encouraging the alcoholic to talk about personal problems AS HE/SHE SEES THEM.

c. The counselor's job is to assist the alcoholic to see any relationship which exists between "hurt points" and his/her drinking.

(1) Information from the alcoholic may be distorted or incomplete at the beginning to "feel out" the counselor's willingness to listen, accept, and understand (rapport).

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(2) The counselor must resist the temptation to pressure the client to give more information (remember guilt defense mechanisms previously mentioned).

d. The important point to remember is that whether or not the alcoholic gives an accurate picture of his/her drinking, his/her discussion of it gives the counselor an opportunity to plant seeds of understanding and seeds of creative anxiety.

e. Some questions to ask the client regarding personal perception of his/her drinking are:

(1) Do you sometimes find yourself drinking more than you intend?

(2) Do you ever get a bit defensive when your spouse questions you about whether you are drinking too much?

f. The defensive alcoholic often will deny that he/she has had any experiences mentioned by the counselor.

(1) The effort was not wasted.

(2) The counselor may have helped the alcoholic to begin to recognize the symptoms of alcoholism in his/her drinking behavior.

(3) Creative anxiety was sown by the counselor which may flower into willingness to face the reality of a drinking problem.

3. Explain that once the alcoholic begins to become more open to help, it is advisable, as a third guideline, to emphasize the physical component in alcoholism.

a. Drawing an analogy between the alcoholic's problem and allergic reactions is an effective way of communicating to the alcoholic that his/her illness is a reality, and treatment is essential to recovery.

(1) Psychological explanations still carry overtones of moralism and "freewillism" in our culture.

(2) Medical analogies seem to escape these overtones.

(a) This area serves as a bridge to accepting the physiological components in the illness of alcoholism.

(b) Conditions in allergy or diabetes as an analogy with alcoholism have characteristics of being incurable BUT TREATABLE. Both must live within limitations imposed by their conditions.

(c) Both conditions involve a malfunction of the organism and, if untreated, becomes progressively more severe.

b. The counselor should presume the presence, in some degree, of resistance.

(1) Openness may subside as the pain and memory of the suffering resulting from excessive drinking subside.

(2) The alcoholic then begins to question whether or not he/she really is an alcoholic, since he/she feels so well and is obviously in competent control of his/her life. At this point, the person's knowledge of the nature of the illness (including the tendency to rationalize) can help the person resist taking a course that will probably eventuate in a drinking bout.

EVALUATION

1. What constitutes the difference between motivation and a lack of it in the alcoholic?

2. What three guidelines should be employed in couseling the resistant alcoholic?

3. Why might it be difficult for a counselor to accept the rejection of help by the alcoholic?

4. Is an accurate account of the drinking history by the alcoholic important?

PRESENTATION

2e CRITERION OBJECTIVE: Identify five reasons for problem denial by the alcoholic, the meaning of constructive confrontation, and the importance of stressing client responsibility.

1. Identify the five factors which result in the alcoholic's denial of his/her problem.

a. Fear of the pain of abstinence (life without the pain killer).

b. Fear of not belonging to a drinking group (which is enjoyable).

c. Feeling that alcohol is all that matters.

d. Blow to self-esteem of admitting loss of control.

e. Fear of what it might do to job, family, church, or social relations to be identified as an "alcoholic."

2. Explain that implicit in these fears is the values clarification process; i.e., prize, choice, and action (PCA), plus viable alternatives.

a. It is important that the counselor deal with empathy and understanding when the client is admitting a need for help with these inner barriers.

b. If the client can bring fears into the open, the help of the counseling process becomes available for coping with them.

3. Explain that constructive confrontation is one of the many forms of help.

a. The alibi system can be dealt with in this manner through the technique of "I have a hunch."

b. By showing understanding of how difficult it is for the alcoholic to let go of alibis, the counselor may help him/her to do so.

c. If the alcoholic is "ripe" for treatment, this direct attempt to reduce the operation of his/her rationalization system may be effective.

(1) If not, the alcoholic may become more defensive for the time being; but, the seeds of recovery may have been planted.

(2) If the person is obviously defensive, it is wise to understate the case and, thus, avoid a head-on collision with his/her defenses, which only makes them more rigid.

4. Explain that constructive confrontation means confronting the person with reality and helping him/her look at it squarely.

a. The alcoholic may resent the counselor's picture of the truth of his/her drinking and its consequences. Yet, in spite of this, constructive wheels may be set in motion in the alcoholic's thinking.

b. Offer help and hope, at the same time holding up reality (PCA) firmly and acceptingly. It is less difficult for the alcoholic to face the grim fact that his/her life is in shambles because of drinking, if he/she knows there are effective ways of stopping and rejoining the human race (viable alternatives).

5. Explain that it is essential to keep the responsibility for recovering with the alcoholic.

a. Only the alcoholic can get or stay sober. It cannot be done

for him/her. The alcoholic must accept this responsibility or he/she is lost.

(1) The alcoholic's dependent side tends to draw the counselor into the trap of assuming responsibility for the alcoholic's sobriety.

(2) The alcoholic likes to see the counselor as a "wonder-worker" who can "cure" him/her of alcoholism.

(3) Let the alcoholic know, gently but firmly, that no one, including God, can cause him/her to recover from alcoholism unless he/she takes the initiative and is willing to work for recovery.

b. To avoid becoming ensnared in assuming responsibility for the alcoholic's sobriety or lack of it, the counselor must strive not to become ego-involved in the outcome of the counseling process (need for success). This is the one kind of counseling wherein a counselor's "success drive" is detrimental to both the counselor and the client.

(1) The counselor loses confidence and sense of accomplishment and respect for the client.

(2) The alcoholic may sense that the counselor has too great a stake in his/her getting sober and has a "weapon" to use against the counselor in periods of hostility and anti-dependency.

(3) The alcoholic can frustrate the counselor by not moving into sobriety.

(4) The alcoholic may detect this desire for success as being manipulated (connotive sense) and react to the counselor in the same way he/she would to a mission worker who gives the alcoholic the impression that he/she is interested in the alcoholic as an opportunity to save a soul.

(5) When the alcoholic playing the game of "Wino" puts him/herself in an untenable position in order to get help, he/she is saying that people in power positions who could really help are "not OK." They wait until he/she is nearly dead before they help.

APPLICATION

1. In a small group, have the students role-play the four counseling roles (see Attachment 1).

2. The four counseling roles deal specifically with four distinct alcohol behavior patterns. Assign the roles, one at a time, to students, who will act as counselor and client. Allow at least ten to fifteen minutes for each role.

3. At the end of each simulated counseling session, process the counseling session, process the counseling techniques employed, the possible "game" the client was in, and the disengagement techniques used. Total time for

processing should not exceed fifteen minutes.

4. Two roles per hour should be accomplished and processed.

CONCLUSION (10 Minutes)

SUMMARY

1. To understand the counseling relationship with alcoholics, it is necessary to determine what is an alcoholic and what is alcoholism.

2. The three principles of counseling involved in understanding the alcoholic and alcoholism involve self-examination of personal values and definitions in areas of freedom and determinism acceptance, and enabling the client to deal with the reality of his/her world through understanding.

3. Motivation on the part of the counselor and the client is important! Examination of the ten questions to determine client motivation is paramount to understanding the client's intentions and the role that alcohol is playing in his/her life.

4. Dealing with the resistant alcoholic involves the acceptance of his/her right to fail and finding out where his/her "hurting points" are. Finally, the physical components of alcoholism must be emphasized.

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5. A knowledge of the alcoholic's reasons for denial will assist the

counselor in the "enabling" function. Important in this area is the concern over constructive confrontation.

REMOTIVATION/CLOSURE

1. As drug/alcohol officers and noncommissioned officers, the misinformation and attitudes of the populace will be your major concern in dealing with the alcoholic.

2. Alcohlism is the most misunderstood condition. It is receiving more and more importance within and without the military.

3. The alcoholic will employ more defense mechanisms to stop assistance than any other type of counselee. Knowledge of this resistance and self-examination of personal attitudes is paramount.

4. Thank you for your participation and attention.

ASSIGNMENT

Give complementary technical training assignment, if appropriate.

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COUNSELING THE ALCOHOLIC

Role-Playing

1. ROLE I. Your reasons for using alcohol are, as stated by you, associated with the work situation. Your object is to "goad" the counselor into getting you into a more favorable job, which will enable you to control your drinking. In actuality, you are denying that alcohol is the problem, and projecting the cause and nature of your trouble on to the job. You are rationalizing, in order to avoid facing the real problem -- YOU AND ALCOHOL.

2. ROLE II. You are not willing to abstain totally from alcohol, and use the following studies as justification:

a. Cain, The Cured Alcoholic, 1964. "It is possible, with the exception of alcoholic psychotics, for any alcoholic to learn to drink normally."

b. Davies, Normal Drinking in Recovered Alcoholics. In 100 cases, seven out the 100 were able to drink normally.

ATTACHMENT 1

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3. ROLE III. You are a counselee who, on his third session with the counselor, has still not completed the task which was assigned during the first meeting. In addition, the counselor has found out, by your own admission, as well as from your wife, that you have been unable to remain sober. You are very apologetic to the counselor and promise that a failure like this will never happen again. You cite the domineering, overreacting, persecutor-like behavior of both your wife and your boss as the cause of your failure.

INSTRUCTIONS:

Work around to some concession from the counselor, such as a few days off to "pull yourself together." Your goals are to deny your alcoholism and to set the counselor up as a "persecutor" or a "patsy."

4. ROLE IV. You are a counselee who has a variety of "angles" that you will play with the counselor, in order to secure gratification on the one hand, and prove that nobody loves you on the other. Your main problem is that your wife is incapable of showing you the affection that you require. You typically start drinking at home, and then attempt to make love to your wife, who pushes you (a drunk) away. You leave to seek your affection elsewhere. On this occasion, you have brought your wife with you to work with the counselor. She insists that you are the problem, not her, and, therefore, refuses to participate in treatment, or the conversation.

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STUDY GUIDE

3ALR73430B/30LR7361B/30ZR7364B-III-1-1

Technical Training

Drug and Alcohol Abuse Control

Counseling Techniques

PART IV - COUNSELING THE ALCOHOLIC

1 August 1978

USAF TECHNICAL TRAINING SCHOOL
Lackland Air Force Base, Texas 78236

DESIGNED FOR ATC COURSE USE. DO NOT USE ON THE JOB.

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ATC FORM 214 (JAN 78) OBSOLETES ATC FORMS 214, MAY 68, 322 NOV 63 AND 822, MAY 71. STANDARD COVERSHEET

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SG 3ALR73430B
Social Actions Training Branch 30LR7361B/30ZR7364B-III-1-1
Lackland Air Force Base, Texas 1 August 1978

Counseling Techniques

PART IV - COUNSELING THE ALCOHOLIC

OBJECTIVE

Identify basic principles and techniques for counseling alcoholic clients.

INTRODUCTION

As a result of reading this SG, you will be able to better understand the alcoholic and the workings of the alcoholic mind. How to understand and counsel the alcoholic and what can be done for him/her are on the top of the list of problems which prove most puzzling to the counselor. Alcoholism, as described by Alcoholic's Anonymous, is "cunning, baffling, and powerful" and will require all of the counselors creativeness, caring and resources to deal with. However, dealing with alcoholics should be looked upon as a major opportunity as well as a major problem for the counselor. All is not lost, nor is the work futile, there are glimpses of victory in the face of the recovered alcoholic that you helped on the road to a better and happy life. The guidelines presented to you in this study guide are tried methods that have worked in the past and can work for you. Your attitude toward the alcoholic will have a direct relationship on the number that actually come to you for help. Helping the alcoholic toward his/her full potential for personhood, constructive relationships and productive living are excellent goals for which these tools of counseling can be used.

INFORMATION

REQUIREMENTS FOR SUCCESS

The first basic requirement for success as alcohol abuse counselor is to understand the necessity of enabling the client to deal with reality as the client defines it. Clients suffering from alcohol abuse are confused over "why" they drink the way they do. Since we, as counselors, are unable to find any one psychological or physiological cause of alcoholism, we too, are unable to provide the reasons "why" alcoholics drink the way they do.

It is necessary to understand that under the principle of enabling we as counselors will not "cure" irresponsibility by a direct attack on the drinking habits of the alcohol abuser. Direct attacks only increase the person's guilt-load. Thus, the first basic requirement for success as alcohol abuser counselor involves our understanding the cultural, moral, and educational attitudes which contribute to the al-

coholic's guilt-load. Knowledge of these attitudes assists us to see "reality" as the client defines it.

Cultural. Culturally, we are all products of the "Temperance Movement" in the United States. This attitude first condemned drinking and those that drank. It progressed to claiming that the substance, alcohol, was evil. Guilt the obvious outcome from using this "evil" substance.

Moral. Morally the assumption is that by emphasizing the personal capability of the alcohol abuser, it will make him/her more responsible, and thus more moral. In fact, this attitude increases the defense mechanisms of the client.

Educational. Educationally, alcoholics are seen as "skid row" derelicts. Thus, as counselors, operating under the principle of enabling, we must strive to see the client's definition of reality and provide unconditional, positive regard for the client.

Self Acceptance Increased As Guilt Decreases

The second requirement for success is to help the client become more able to accept him/her self and surroundings. This capacity for self determination comes as the client feels less guilty over the abuse of alcohol; i.e., release from the cycle of guilt makes self-determination possible. There are three ways to assist the client in this release.

INDIVIDUAL SELF ACCEPTANCE. The first way is through the principle of acceptance. Acceptance lowers the alcohol abuser's defenses and allows him/her to face the truth. Remember, acceptance does not mean agreement. Acceptance does not support the guilt-racket nor does it "stroke" the alcoholic behavior. If acceptance is not adhered to by the counselor, the clients need to defend themselves and their behavior will only increase.

ALCOHOLICS ANONYMOUS. The second way to help release the cylce of guilt from the client is through Alcoholics Anonymous (AA). Alcoholics Anonymous gives group acceptance to the client, and also applies the "sickness concept" to alcoholism. The AA approach puts the responsibility for the allergy to alcohol on the "sickness", thus allowing the client to lower his/her personal defense mechanisms for self acceptance and responsibility of behavior <u>without guilt</u>.

CULTURAL STANDARDS. The third way to help release the client from guilt is through our cultural standards. The same culture that provides guilt to the alcohol abuser also urges a "sick" person to receive assistance to arrest and treat the problem. If alcoholism is explained as a disease, the client may be more willing to accept treatment since he/she is not responsible for contracting the disease.

Self Examination

The third requirement for success is that we, as counselors, examine our attitudes towards the fundamental problems of freedom, determination, and personal responsibility. A counselor's relationship can be influenced by heartfelt beliefs concering alcoholism. We must ask such questions as "Is a person free to abuse alcohol to the detriment of health, family, and career?" "Do people have the right to determine that they do not need assistance or treatment for their alcohol problem?" "What are our limits of responsibility of an unwilling client?" etc. Answers to these and related questions will assist us in examining our attitudes towards alcoholics.

MAJOR GOALS AND OBJECTIVES

Major Goals in Counseling The Alcoholic

HELP THE ALCOHOLIC GROW. The first major goal is to help the alcoholic grow toward full potential for full personhood, constructive relationships, and productive living. This assists the client to be happy (OK) with the whole him/her rather than satisfying one part of him/her through alcohol, which only provides temporary satisfaction.

HELP THE ALCOHOLIC ACHIEVE ABSTINENCE. The second major goal of effective rehabilitation counseling is to help the client achieve abstinence from the drug--alcohol. While this is not an Air Force requirement, the Ad Hoc Task Group on Alcohol Abuse established abstinence as a goal of rehabilitation for alcoholics and appropriate problem drinkers. While there is considerable debate in the alcohol treatment field concerning abstinence versus controlled drinking as a goal of rehabilitation, the considered opinion of alcohol program managers, medical personnel, and Alcohol Treatment Center Directors is that abstinence remains the most appropriate goal for all alcoholics and for some problem drinkers. This decision is largely due to the fact that it is impossible to identify that subpopulation for which controlled drinking may be a realistic goal. This position will be continually reevaluated in light of new research and treatment techniques in order to insure it remains an appropriate goal. Since change cannot occur until the drug is removed, abstinence is a realistic goal for alcoholics. To help the client achieve abstinence, it may be more realistic to aim for more limited goals; e.g., reduction of the number of bingers over a given period; days lost from work due to hangovers; reduced number of DUI/DWI's; etc. Here, the AA idea of "one day at a time" can be applied very effectively.

Objective In Counseling The Alcoholic

Included under these goals are four objectives. They are seen as overlapping stages of treatment. The objectives are to help the alcoholic:

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ACCEPT DRINKING IS WHY HELP IS NEEDED. The first objective is for the client to accept the factor that his/her drinking is a problem, which needs help. Not until this objective is accomplished will any treatment be successful. Using the AA model, the very first objective of their program is admitting to self that alcohol is a serious problem in their lives. This objective is clearly seen when an alcoholic in an AA meeting announces to self and others, "I'm Mary, and I'm an alcoholic".

OBTAIN MEDICAL TREATMENT. The second objective is to obtain medical treatment. This is needed not only for the official diagnosis of an alcohol problem, but serves to render medical assistance to physical and emotional problems which resulted from the abuse of alcohol; e.g., nephritis (inflammation of kidneys), severe emotional dependence.

INTERRUPT ADDICTIVE CYCLE. The third objective is to interrupt the addictive cycle and keep it interrupted by having the client learn to avoid the first drink. The Air Force does not require complete abstinence of a recovering alcoholic in order for the person to be considered a "successful rehabilitee". The Air Force only requirement for success is the person's ability to adequately perform at his/her job and adequate social behavior as it affects the U.S. Air Force. If alcohol is a problem that is causing problems with a person's job and/or social behavior, a realistic objective of any therapeutic regimen for a recovering alcoholic would be complete abstinence, although not required by Air Force regulations.

REDEVELOP A NEW LIFE WITHOUT ALCOHOL. The last objective is for the person to achieve a resynthesis of his/her life without alcohol. This objective refers to the second requirement for success in counseling the alcoholic (client's acceptance of self and surroundings).

Referrals. Obviously we in Social Actions cannot accomplish all the goals and objectives alone. Team effort is needed! The minimum tean membership consists of the following: physician, AA, the counselor, the alcoholic. The counselor is the coordinator for the referral to the other team members.

A danger with referrals is that it may be viewed by the client as rejection. Explanation to the client for the rationale of referral is a must! Referral must be seen as a sharing of responsibility, not as a shifting of responsibility. Counselors may view referrals as "Letting George do it". It is critical that counselor thoroughly examine his/her strengths and weaknesses. If the client legitimately cannot receive assistance from you, then refer the client to someone who can. Referral means that we keep "track" of the client while with the referral agency, thus not "feeding" the client's fear of being rejected due to their alcohol problems.

MOTIVATION AND QUESTIONS TO DETERMINE IT

Defference Between Motivation and Lack of It

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INADEQUATE MOTIVATION. Inadequate motivation is the result of the alcoholic's seeing alcohol as a solution. What the client wants is help in avoiding the consequences of personal behavior or the crisis circumstances he/she feels confront him/her at the time. This can be seen in the client who comes into Social Actions after a DWI and announces to the counselor, "I'm here because I want to keep my commander off my back." This client may not see that his commander is "on his back" because of the DWI which was caused by his drinking; all he sees is the result (consequence) of his drinking. In inadequate motivation the client does not see, or is unwilling to admit, that his/her drinking is causing the problems in his/her life.

ADEQUATE MOTIVATION. On the other hand, adequate motivation is present when the alcoholic sees alcohol as one factor which contributes to personal problems. In other words, "the drinking in my life is causing me problems". Thus, the key question in determining the alcoholic's motivation is, "Is the alcoholic able to admit that alcohol in giving him/her serious troubles and that he/she needs help?"

Questions To Determine Clients Motivation

The discovery of the nature of an alcoholic's motivation can be accomplished through a variety of questions in the first interview. By determining the client's motivation early, the counselor can recommend a much more effective rehabilitation regimen. All of the following questions need not be asked. Ask enough questions to gain a picture of the alcoholic's motivation and the help needed or expected.

WHY IS THE ALCOHOLIC HERE NOW?

WHY DID THE ALCOHOLIC SEEK HELP NOW?

WAS THE ALCOHOLIC THREATENED OR "DRAGGED" INTO COMING TO YOU BY SPOUSE OR SUPERVISOR?

Is there some special crisis which puts the alcoholic under acute pressure at the moment, but which will pass? These questions can give the counselor a very good idea of how the client got to Social Actions. Often the alcoholic is responding to pressure from home. "Either you get help or I'll leave!"; the job, "Either you go to Social Actions or I go to the commander with my documentation." With the answers to these questions, the counselor can not only understand the pressure the client may be under, but can also gear the sessions to "reach" that client; maybe tender and supportive or tough and confrontive.

DETERMINING THE PROBLEM.

WHAT DOES THE ALCOHOLIC SEE AS HIS/HER PROBLEM?

From the alcoholic's point of view, is drinking a problem or a solution? Initially, most alcoholics don't see the connection between

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their life problems, and alcohol. They see their spouses' nagging or their supervisor's hasseling as the problem and alcohol as the solution. In cases like this the counselor can keep pointing to reality--if you didn't drink so much , your wife would not nag you about being drunk; if you didn't spend so much money on alcohol, your husband wouldn't nag you about how little money there is for bills to be paid; if you didn't go to work drunk or with a hangover, your supervisor wouldn't hassle you about not doing your job. Here the counselor is showing the relationship between the problems and alcohol. "When you drink you have these problems."

NEED FOR HELP FROM OTHERS.

Does the alcoholic feel a need for help from others (the counselor)? What kind of help does the alcoholic want? (Pacify spouse, help to drink moderately, stop commander actions, etc.) Sometimes the alcoholic only wants to solve the immediate problem; "Stop my wife/husband from leaving me." The counselor may get "hooked" into solving these problems for the alcoholic by calling the spouse or talking to the commander. Often, what the client wants is not what the client needs. The most effective counselors can use these questions to get a commitment for change from the client.

How Many Questions Asked?

Did the counselor ask enough questions to gain a picture of the alcoholic's motivation? The counselor is not limited to the questions here. By eliminating or adding questions the counselor can establish a basis for a rehabilitation regimen, counseling sessions, and referrals.

GUIDELINES EMPLOYED WITH THE RESISTANT ALCOHOLIC

Right of Client Not to Accept Help

The first major guideline for an alcohol counselor to remember is to accept the alcoholic's <u>right</u> not to accept help. In this guideline is the <u>counselor's need</u> to succeed. Many counselors view this guideline as a personal affront to their professionalism. As a result they buy into the client's game of "save me, if you can" and refuse the client's right to not accept help. The counselor in this game is the rescurer and the alcoholic the victim. Yet to the client, the counselor is the persecutor and he/she as the victim.

Discover "Hurt Points"

The second major guideline is to discover the point(s) where the client is hurting. This is a time when help is most likely to be accepted. These "hurt point(s)" can be found by encouraging the client to talk about personal problems as he/she defines them. Our job as counselors is to assist the client to see the relationship which may exist between the "hurt point" and his/her drinking. The discussion of the problem(s) gives

the counselor the opportunity to plant the "seeds" of creative anxiety, i.e., willingness to face the reality of a drinking problem.

Emphasize Physical Component

The third guideline is to emphasize the physical component of alcoholism when the client begins to become more open to help. Drawing an analogy between the alcoholic's problem and allergic reactions is an effective way of communicating to the client that his/her problem with alcohol is similar to an illness that needs treatment for recovery. Psychological explanations still carry overtones of moralism and "freewillism" in our culture. Medical analogies seem to escape these overtones. An example of this is to compare alcoholism to diabetes. Both sufferers must live within limitations imposed by their conditions. Both conditions involve a malfunction of the organism and if untreated, becomes progressively more severe. Both conditions are treatable. This guideline allows the client to set aside the issue of drinking and thus deal with the causes of the condition.

WHY PROBLEM DENIAL, CONSTRUCTIVE CONFRONTATION, AND WHY STRESS RESPONSIBILITY

Why Alcoholics Deny The Problem

FEAR OF PAIN OF ABSTINENCE. The first factor is the fear of the pain of abstinence (life without the pain killer). Involved in this factor is the fear of the pain of withdrawal. It may be necessary to help the client overcome this fear by giving limited goals, as discussed previously.

FEAR OF NOT BELONGING. The second factor is the fear of not belonging to a drinking group (which may have been enjoyable). As members of a drinking group, the alcoholic has a sense of belonging to a group that provides him/her with a support system, which may be dysfunctional, but is all the alcoholic has. To give up the "drinking buddies" may also mean giving up the only support system the alcoholic has to cope with life.

FEELING THAT ALCOHOL IS ALL THAT MATTERS. The third factor is the alcohlic's feelings that alcohol is all that matters in his/her life. For the alcoholic, the drug becomes the primary concern over friends, family, job. Integrating the client back to his/her job and socialization with other non-alcoholics becomes critical in dealing with this fear. Then other people and things can become primary concerns rather than alcohol.

BLOW TO SELF-ESTEEM. The fourth factor is the blow to the alcoholic's self-esteem by admitting his/her loss of control over alcohol. For the alcoholic to admit that he/she can't "handle their liquor" can be very dramatic; especially when he/she thinks that he/she is the only person with the problem. This fear often leads the client to hang onto his/her

denial of the problem.

FEAR OF STIGMATIZATION. The last factor is the fear of the label "alcoholic." Unfortunately, many people and institutions still label alcoholics as moral degenerates. Consequently, many alcoholics fear what the label might do to job, family, church, or social relationships. The stigma must be dealt with since it is a real concern to the client.

UNDERSTANDING FEARS. The client will often use the fears to continue to deny a problem with alcohol. By bringing these fears into the open and discussing them the help of the counseling process becomes available for coping with them. The client begins to see that he/she is not the only one with these concerns and that there is a way of dealing with them. By showing understanding to the client of how difficult it is for the alcoholic to let go of alibis, the counselor may help the client to do so without causing an increase of guilt.

Meaning of Constructive Confrontation

Constructive confrontation means confronting the client with reality and helping him/her look at it squarely. Constructive confrontation is one of the ways to deal with the denial system. If the client is "ripe" for treatment, this direct attempt to reduce the operation of his/her rationalization system may be effective. The client may resent the counselor's picture of the truth of his/her drinking and its consequences. Yet, in spite of this, constructive wheels may be set in motion in the client's thinking that help is available. The counselor's job is to provide help and hope while holding up reality firmly and acceptingly. It is less difficult for the alcoholic to face the fact that his/her life is in shambles because of drinking if he/she knows there are effective ways of stopping and rejoining society.

Stressing Client Responsibility

It is essential to keep the responsibility for recovery with the alcoholic. Only the alcoholic can get or stay sober. He/she must accept this responsibility or the effort is lost. The counselor, can establish the therapeutic regimen for sobriety, but only the alcoholic can accomplish it! Remember the client has been dependent on alcohol to solve his/her problems in the past, and will now try to draw the counselor into the trap of assuming responsibility for the sobriety. To avoid becoming ensnared in assuming responsibility for the client's recovery to lack of it, the counselor must strive not to become ego-involved in the counseling process (the counselor's need for success). If the counselor takes on the client's sobriety as a "make it or break it" for the counselor's ego, the client will allow the counselor to frustrate him/herself by always coming close to sobriety but never quite reaching it. The alcoholic will sense that the counselor has too great a stake in his/her getting sober and use this as a "weapon" to use against the counselor in periods of dependency of hostility. Thus the counselor loses confidence and sense of accomplishment, as well

as respect for the client. This is a heavy price to pay for satisfaction of his/her need to succeed.

SUMMARY

The basic requirements for success as an alcohol counselor are: enabling the client to deal with reality as the client sees it; to help the client become better able to accept him/herself; and counselor self examination of personal values.

The major goals in counseling the alcoholic are: to help the alcoholic grow towards full potential, and to help the alcoholic achieve abstinence. Included in the goals are essential objectives; to help the client accept that drinking is why help is needed, to obtain medical treatment, to interrupt the addictive cycle, and for the alcoholic to redevelop life without alcohol.

The difference between motivation and the lack of it, on the part of the client, depends on how the client sees alcohol in his/her life. Examination of the ten questions can help to understand the client's intentions and the role of alcohol in his/her life.

Dealing with the resistant alcoholic invovles the acceptance of his/her right to fail and finding out where he/she is hurting; as well as emphasizing the physical components of alcoholism.

Knowing the reasons for the alcoholic's denial will assist the counselor in the "enabling" function. Important in this area is understanding constructive confrontation.

The field of alcohol counseling is still very new. The information in this study guide is an outline of some of the forward dynamics of work in a counseling session with an alcoholic. Using these guidelines will help you to gain more confidence and expertise in counseling the alcoholic.

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SOCIAL ACTIONS TRAINING BRANCH
Lackland Air Force Base, Texas

LP BB-III-1.4 (1)
1 August 1978

ALCOHOLISM COUNSELING ROLE

COUNSELING ROLE

You are a counselee who, on his third session with the counselor, has still not completed the task which was assigned during the first meeting. In addition, the counselor has found out by your own admission, as well as from your wife, that you have been unable to remain sober. You are very apologetic to the counselor and promise that a failure like this will never happen again. You cite the domineering, over-reacting, persecuter-like behavior of both your wife and your boss as the cause of your failure.

Instructions:

Work around to some concession from the counselor, such as a few days off to pull yourself together. Your goals are to deny your alcoholism and to set the counselor up as a persecuter or a patsy.

COUNSELING ROLE

You are a counselee who has a variety of angles that you will play with the counselor in order to secure gratification on the one hand and prove that nobody loves you on the other. Your main problem is that your wife is incapable of showing you the affection that you require. You typically start drinking in the home, and then attempt to make love to your wife, who pushes you (a drunk) away. You leave to seek your affection elsewhere. On this occasion you have brought your wife with you to work with the counselor. She insists that you are the problem, not her, and therefore refuses to participate in treatment, or the conversation.

Attachment 1

Designed for ATC Course Use
Do NOT Use on the Job

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COUNSELING ROLE

Your reasons for using alcohol are, as stated by you, associated with the work situation. Your object is to goad the counselor into getting you into a more favorable job, which will enable you to control your drinking. In actuality you are denying that alcohol is the problem, and projecting the cause and nature of your trouble onto the job. You are rationalising, in order to avoid facing the real problem, YOU AND ALCOHOL.

COUNSELING ROLE

You are not willing to abstain totally from alcohol, and use the following studies as justification.

A. Cain, The Cured Alcoholic, 1964
"It is possible, with the exception of alcoholic psychotics, for any alcoholic to learn to drink normally."

B. Davies, Normal Drinking in Recovered Alcoholics
In 100 cases, 7 out of the one hundred were able to drink normally.

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LP 3ALR73430B/30LR7361B/30ZR7364B

LP B-III-1.5
COUNSELING TECHNIQUES
(Referrals)

PART II - TEACHING GUIDE

INTRODUCTION (5 Min)

ATTENTION

Drug and alcohol abuse can be a multifacted problem. The problems caused by the abuse can extend into all areas of an individuals life - sexual, marital financial, legal or medical. For this reason rehabilitation is seen as a team effort. Your job in Social Actions will be to help your clients get the assistance they need to accomplish their rehabilitation. The best way you can do this is through effective use of referrals.

MOTIVATION

Social Actions can become the "catchall" for everyone on base with a problem. While we may want to help, in many cases we can't. We may not have the expertise, time, people, or responsibility. By using referrals effectively we can insure that those people we can't help are helped.

OVERVIEW

1. Steps in establishing and maintaining meaningful referral resources.

2. The correct procedures for conducting referral interviews and provide appropriate referral follow-up.

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a. Reasons for referral.

b. Preparing to refer.

c. Procedures to follow.

d. How to refer.

e. How to follow-up.

TRANSITION

We will begin by looking at referral resources.

BODY (2 Hrs 50 Min)

PRESENTATION

1e. CRITERION OBJECTIVE: Identify the steps in establishing and maintaining meaningful referral resources.

1. Explain making a list of available resources.

a. On base ("brainstorm" with class).

b. Off base.

(1) Check telephone book.

(2) Ask around; i.e., community mental helath, social workers, welfare, etc.

2. Stress checking out resources.

a. Ask others who have been there.

b. Go to see them.

(1) Tell them who you are.

(2) Ask what they do and if they will take referrals.

(3) If referrals are accepted, under what conditions?

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3. Stress selecting best resources.

a. If referral agency won't answer b(2) and (3), don't refer.

b. Check agency qualifications.

4. Stress publishing a reference guide (Air Force Regulation (AFR) 30-2, Chapter 3).

a. List of problems keyed to appropriate referral agency(ies).

b. Annotated listing of all resource agencies used.

c. Follow-up file.

EVALUATION

1. What are the four steps to making a referral?

2. Should you use all available resources for client referral?

3. What does AFR 30-2 require of each Social Actions office regarding referrals?

TRANSITION:

1f. CRITERION OBJECTIVE: Identify the correct procedure for conducting referral interviews and providing appropriate referral.

1. Reasons for referral.

a. Explain the first reason: Long-term therapy, or too much time needed now.

b. Second reason: Beyond your capability.

(1) Know your limitation as part of your job.

(2) Never promise more than you can deliver.

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c. Third reason: Need for confirming opinion (alcoholic diagnosis).

d. Fourth reason: Need for extra help (explain shared-responsibility concept).

(1) Most common referral reason.

(2) "Shared" doesn't mean abdication of responsibility.

e. Fifth reason: Some other agency can "get through" better. ("Wall-to-wall" counseling from a first sergeant is good for some people).

TRANSITION:

EVALUATION

Give an example of when you may need to refer a Social Actions client.

2. Recommended counselor actions for self and client preparation, when client referral is anticipated.

a. Discuss counselor preparations for the interview.

(1) Review of counseling records (if established).

(2) Review of referral sources.

b. Emphasize the importance of finding out what the client needs.

(1) First, question what the client wants.

(2) Clear up ambiguous responses.

(3) Establish what client really needs.

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c. Explain how to establish the referral itself.

(1) Reflect the problem area based on what the client needs.

(2) Attempt to gain a commitment to change from the client, so that client will gain maximum from the referral.

(3) Indicate the appropriate helping agency that can best help the client.

EVALUATION

1. How should the counselor prepare for an interview when a referral is anticipated?

2. What process does the counselor guide the client through to determine a referral based on client needs?

3. Why is it important to attempt to gain a committment to change from the client before referring?

TRANSITION:

a. Explain the first step: Document the referral consult.

(1) Make behavioral statements or quote verbal responses.

(2) Don't label; just describe behavior.

(3) Labeling can get you into legal and professional trouble.

b. Second step: Escort, in some situations. (Refer to pathology symptoms in Mental Health Terminology lecture).

c. Third step: If possible, get the client to call (in your presence).

(1) Helping client to take responsibility.

(2) Increases probability of client making appointment.

(3) Refer to one agency at a time.

(4) Where possible, refer to a particular person at an agency.

d. Fourth step: Follow-up.

(1) Mandatory under provisions of AFR 30-2.

(2) Most common weak area.

4. How to provide follow-up:

a. Effective follow-up proceudres can:

(1) Give feedback on effectiveness of referral agencies.

(2) Verify that client received the assistance needed.

(3) Demonstrate your concern for the client.

(4) Increase your credibility with the referral agency.

b. Identify how to provide follow-up.

(1) Ask client to call you with his/her perceptions of assistance provided by agency.

(2) Call agency and ask about client's progress.

(3) Request written report/consult from agency.

EVALUATION

1. What are four procedures to follow when referring a client.

2. What guidelines should you use when documenting a referral consult?

3. How can effective follow-up help insure the credibility of the referral.

APPLICATION

Direct students to small groups. Based on role-playing situation (Attachment 1), have students formulate and discuss referral to be made. Use referral exercise (See Attachment 1).

CONCLUSION (5 Min)

SUMMARY

Today, we have examined:

1. Steps in establishing and maintaining meaningful referral resources.

2. The correct procedures for conducting referral interviews and provide appropriate referral follow-up.

   a. Reasons for referral

   b. Preparing to refer.

   c. Procedures to follow.

   d. How to refer.

   e. How to follow-up.

REMOTIVATION

Appropriate referrals can be a courageous and vital decision. Though we may feel an obligation to help everyone, we must learn to recognize and accept our limitations. Many individuals have problems requiring help beyond our training and capability.

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If referral is the result of fore-thought, research, and coordination, it becomes an extension of services, rather than a put-off.

CLOSURE

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REFERRAL EXERCISE

1. Inform students that they will be required to formulate a referral based on a role-playing situation with you as client and a student as counselor.

2. Facilitators role as client should include a drug or alcohol problem in addition to other associated problems (legal, medical, financial, martial, etc.). Be sure that the role has a built-in need for referral.

3. Choose students counselor and conduct the counseling session. (Should last about 20 min.)

4. After counseling session, have students formulate the kind of referral they would make. Have them include why, to whom, when, and how the referral would be made, and how they would provide follow-up. Also, have them state what they would document in a referral consult.

5. After all students have formulated their referrals, facilitators will lead a discussion on the referral process used. Some points for discussion are:

   a. What is the client's problem(s)?

   b. What are the strengths/weaknesses that you see in the client?

   c. What referrals would you make? Why? To whom? How?

   d. How do you feel about referring a client you can't help?

   e. How would you document the referral consult?

   f. How would you provide follow-up?

   g. Any other items facilitator thinks appropriate.

6. Approximate Timing:

HR/MIN	
0000	Lecture
0050	Break
0100	Instruction
0105	Role Played Referral
0125	Students formulate referral
0150	Break
0200	Students discuss questions in #5 above.
0245	Summary, remotivation, and closure.
0250	Break

ATCH 1

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STUDY GUIDE AND WORKBOOK

3ALR734308/3OLR73618/3OZR73648—III-1-18

Technical Training

Drug and Alcohol Abuse Control

GENERAL COUNSELING TECHNIQUES

PART IV

(REFERRALS)

3 January 1977

USAF SCHOOL OF APPLIED AEROSPACE SCIENCES
Social Actions Training Branch
Lackland Air Force Base, Texas

Designed For ATC Course Use

DO NOT USE ON THE JOB

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PART IV

GENERAL COUNSELING TECHNIQUES (REFERRALS)

OBJECTIVE

Identify four steps in establishing meaningful referral resources.

INTRODUCTION

Being able to easily refer a client to the agency that can best handle the client's specific type of problem is essential to success in social actions counseling. How do we compile a checklist of handy referral agencies which will be beneficial to us? How do we use this list effectively? The following information will give some handy tips for developing meaningful referral resources.

INFORMATION

REFERRAL RESOURCES

Step One: Make a List of Available Resources

One of the best ways to make lists of available resources is to brainstorm. You and your staff often have more knowledge about referral resources than you might think. You can try brainstorming with other groups such as base drug/alcohol education classes, the Drug/Alcohol Abuse Control Committee, or a rehabilitation committee. You also can consult the base or civilian phone directories, or referral lists other agencies have already prepared. Whatever you may use to prepare the list, you'll want to be sure to include both on- and off-base resources.

ON-BASE RESOURCES. Social actions personnel must have a comprehensive list of available on-base resources. You'll need to know who and when these on-base agencies service, and how adequate they are. Brainstorming, checking with other base helping agencies, and the phone book are all good ways to develop a comprehensive list.

OFF-BASE RESOURCES. Developing a list of off-base resources is similar. In addition to brainstorming, consulting the civilian phone book, and asking around, you may be able to use a resource list already developed by the community mental health center, public welfare, the local "hot line," or interagency council. While you're collecting the names, locations, services provided, and phones of these off-base agencies, do not forget to find out how much they charge for services rendered and if this charge is adjustable depending on the client's income.

Step Two: Check Out Referral Agencies

It is extremely important to remember that you should always check out proposed referral agencies before sending a client over to use that agency. At best, sending a client to an unknown agency could be a waste of time; at worst, the agency could be counterproductive and/or cost a lot of money. In order to know how an agency can best help your client, you must be very familiar with the quality of services that agency offers. Some ways of checking our resource agencies are listed below.

ASK THE EXPERIENCE OF OTHERS. Ask others who have been to, investigated, or used the particular agency. Find out their opinion of how the agency helped them or their client. Would they recommend the agency to others? Was the cost worth the benefits? Are there particular individuals you should see to gain maximum help?

VISIT THE AGENCY. Go see them for yourself. It is very important that you make the referral agencies aware of what social actions does, and why you would like to refer clients to them. Let them know who you are and what you do. Then ask them what they do and if they will take referrals. Find out their admission criteria, if payment for services is required, and to whom your referred clients should come for help. Find out their willingness to provide social actions with feedback on referred clients. By making a personal visit to the referral agency, drug/alcohol abuse control specialists can get acquainted with key agency personnel and establish working relationships with specific people so as to insure smooth referral and maximum feedback.

Step Three: Select the Best Resource

Do not select just any resource for your referred client or your referral list. Select only the best ones for your list, and only the ones which meet the needs of your client. When you find out the information requested above when visiting the agency, you'll be better able to select the best agency to meet your or your client's needs. If the agency won't answer what they do, what their admission criteria are, if money will be required for treatment, then do not refer to that agency. Remember, there are both "best" agencies, and "best" people at those agencies. Know the people who are most helpful to your particular type of client. Build a working relationship with these people, and refer your clients directly to these people. This will facilitate the referral process, and provide you with better feedback.

Step Four: Publish a Reference Guide

A ready reference guide is a good tool for organizing and expediting the mechanics of the referral process. You can imagine how much more complicated referral would be if you have to look through the telephone directory while your client sits tapping his/her fingers. It is best to have a guide that selects only the best resources so that you only have to examine which are the best of the best to meet the needs of your clients. AFR 30-2 gives the following suggestions to design a reference guide:

INDEX. Have an index which presents a list of problem types expected, followed by a number keyed to the appropriate referral agencies. This is particularly helpful in crisis situations or during telephone counseling. A good index makes you look good—competent, that is.

ANNOTATE. Annotate your list of resource agencies with the following information: the purpose or type of case they handle; phone numbers, key personnel and those who are most helpful; location; hours of operation; and fees (if any).

FOLLOWUP. A followup file is needed to validate whether a particular agency is doing the job you expect. Is the agency credible, responsible? Do they give good feedback? Are you referring the right kind of clients there? Are there other people at this agency that are also helpful?

EXERCISE I

1. What are some of the ways referral agencies might be identified on your base?

2. Why is it important to check out a referral agency?

3. Why should you use only the best referral agencies in your referral guide?

OBJECTIVE

Identify five reasons for referral.

INTRODUCTION

A counselor's decision to refer often interferes with his/her needs for success or recognition. The counselor's ability to understand that the client is not coming to the counselor to fill the counselor's needs is important. If the counselor can believe that he or she has best helped the client when the counselor has steered the client to the person who can best help the client, the counselor can gain satisfaction from a "good" referral. There are basically five reasons for a referral. When you start feeling that you must do everything for your client, examine the following reasons for referral to see if it wouldn't be better to refer the client.

INFORMATION

REASONS FOR REFERRALS

Long-Term Therapy Needed

Sometimes people come to social actions with problems that are severe in nature and the problems they have require medical attention, therapy, or long-term monitoring. You

remember the signs of mental illness given in the Mental Health Terminology unit of instruction. If these signs appear in people you are interviewing or counseling, it is time for a referral. Social actions office personnel, ordinarily, are not trained or manned to do long-term therapy. If the person is classified an "addict," if he/she will need more than 45 days of rehabilitation or more than 1 year of follow-on monitoring, then your job is to refer the person to a place which has the expertise and manning to help that person. In social actions, we do short-term rehabilitation.

Beyond Your Capability

Though we in social actions may feel obligated to help everyone who comes to our door, we must recognize our own limitations. We cannot help everyone. Tackling a problem that is beyond our scope of adequacy and training can do more harm than good. Promising more than you can give not only misleads the client, but also obligates your time to be spent doing the things you are least capable of. Sometimes it is difficult to accept the fact that you do not know how to deal with certain kinds of cases, but it may be best for your client and you.

Need for Confirming Opinion

At the very minimum, all drug and alcohol rehabilitees will need to be referred to the medical authorities for a medical evaluation and/or diagnosis. There are many other situations in which the social actions counselor needs confirming opinions. You may choose to have mental health evaluate the need for referral to the alcohol treatment center or have the client remain at base level rehabilitation; for mental health to confirm or deny your belief that assignment to social actions group counseling is best for the client; and so on; the list is endless. A confirming opinion gives you, the counselor, the benefit of the experience, training, and different perspective of another agency/person. Using a confirming opinion can be a creative way to not only help your client, but also continue the learning process.

Need for Extra Help

In many cases the social actions counselor will need additional help in dealing with clients. Recognizing this need is a sign of strength, not weakness. Sharing responsibility for the treatment of clients can benefit clients by having the agency with the expertise help that aspect of the client which that agency does best. For example: The client whose financial situation is a mess may need assistance from the legal or finance office, or even counseling by the first sergeant. Social actions does not abdicate responsibility for the client's rehabilitation just because the client is referred for this kind of help. In this case, there is shared responsibility. In another case, referral to the central alcohol treatment center for extra help is only a temporary referral. When the client returns from the extra help, social actions will continue the follow-on support, hopefully, with continuity. Referral for extra help is the most common referral reason. Shared responsibility does not mean abdication of responsibility. It means that social actions will have to monitor the extra help provided by the other agency, and closely coordinate the person's rehabilitation efforts so that all help will be meaningful to the client.

Another Can "Get Through" Better

The most important aspect of counseling is the relationship established. Some client-counselor relationships have the spark necessary to make progress; others may have such conflicting value problems that the relationship cannot get off the ground. Referrals to other counselors should not be looked upon or in fact *be* "buck-passing." Legitimate needs for referral to a person who can "get through" to the client more effectively do exist. Make sure the receiving counselor knows why you believe he/she can get through to the client better. Do not "pawn off" your clients on others at your first frustration. The first frustration may be the time to ask another counselor's advice, or a confirming opinion. Evaluate the need to refer carefully. If you are convinced that another can get through to the client better, discuss the matter with the other counselor and, if you agree, refer. An example of getting through to a client better may be that "wall-to-wall" counseling by the first sergeant might work better for certain types of clients than a nondirective approach which you use best.

EXERCISE II

1. Why is it necessary to know your own limitations as a counselor?

2. Cite two examples of times when you might refer because of a need for extra help.

3. Cite two examples when you might refer when another can "get through" to a client better.

4. Why is the need for long-term therapy a reason for the social actions counselor to refer a client?

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SW 3ALR73430B/3OLR7361B/3OZR7364B—III-1-18

OBJECTIVE

Identify recommended counselor actions for self-preparation and client preparation when client referral is anticipated.

INTRODUCTION

AFR 30-2 states, "If referrals are the result of fore-thought, research, and coordination, they become an extension of services . . . to the client." The following counselor actions will help you make referrals of your clients a real extension of services. These actions begin before you ever see the client by proper preparation through the counselor reviewing the client's record and the potential referral resources. When the client arrives, the counselor needs to ask the client what he/she wants; this will help determine what the client really needs. There are several helpful methods of establishing the referral itself. If you reflect the problem area based on the client's needs, gain a commitment for change from the client, and refer the client to the appropriate helping agency, chances are that the referral will be a success.

INFORMATION

HOW TO PREPARE YOURSELF AND YOUR CLIENT FOR REFERRAL

Preparation Before the Interview

If there is a possibility that you may need to refer a client, it is best to prepare for this possibility in advance of the client's arrival.

REVIEW COUNSELING RECORDS. As always, before the client comes, review the counseling records. Review them with an eye for what possible ways you may be able to help the client. If referral is one way you could help the client, list the possible referrals so that you are aware of the alternatives.

REVIEW REFERRAL RESOURCES. Look carefully at your referral listing to insure that you have reviewed the possible referral resources. This will enable you to remember the alternatives and make the wisest choice from the available referral resources, while paying maximum attention to the client.

Identify What the Client Needs

The way to find out what the client needs is first to ask what the client believes he/she wants, then clear up ambiguous statements, and finally deduce what the client really needs.

QUESTION WHAT THE CLIENT WANTS. If you believe you may need to refer a client, first ask what kind of help the client wants. Ask to see if the client has a preference. By asking what the client wants you may become more aware of how the client sees his/her

problem and what kinds of solutions are acceptable to the client. Remember, it is very important to identify the problem as the client sees it. The client's perception of the problem is what matters.

CLEAR UP AMBIGUOUS RESPONSES. The counselor can identify problem areas by setting up an atmosphere in the counseling relationship that is conducive to the client freely relating information about the problem. This is important since the counselor listens to what the client is speaking and saying with his/her body movements and inflections to evaluate the real meaning of what the client is saying. When the counselor identifies ambiguous responses and inconsistencies, you, the counselor should clear them up. This will help you and the client come to the mutual decision concerning what the client really needs.

DETERMINE WHAT THE CLIENT REALLY NEEDS. What the client says he or she wants may not be what the client really needs. In order to help the client come to the conclusion that he/she really needs a certain type of referral, you, the counselor, will have to clarify the difference between wants and real needs. This is best done by reflecting back to the client what you read his/her real needs are, based on what you see and hear after you have cleared up ambiguous responses.

Establish the Referral Itself

Once you have helped the client determine what he/she really needs, you next establish the referral itself by reflecting the problem area based on what the client needs; attempting to gain a commitment for change from the client; and indicating the appropriate helping agency.

REFLECT THE PROBLEM AREA. Depending on the problem area, you will want to select the referral based on the client's need.

ATTEMPT TO GAIN A COMMITMENT TO CHANGE. Attempt to identify the conflicts in the client's life that are giving him/her problems. Conflicting values or feelings outside the person's awareness may be the problem. Clarify the conflicting values or problems which are causing the difficulties. Attempt to gain a commitment from the client to change; to resolve the conflicts in some way. If the client commits himself/herself to changing, the client will gain far more from the referral. You can imagine how little the client who feels there is no reason to change himself/herself would gain from a referral. You can detect a refusal to change by noting open hostility, disagreement, or passive resistance. Be aware of "parent contracts" which may be in the form of "I should . . . ," "I ought . . . ," etc. These are commitments to change satisfying another's expectations or desires and may be short-lived. A real commitment to change might be something like, "What is causing problems in my life is the conflict between loving my children, wanting to stay with them, and not getting along with my wife, desiring to leave her. I can't have both. I realize this is a big problem to me, and I want to resolve this conflict because it is causing me much pain. I, therefore, am willing to see a family counselor to help me examine this area of my life so that I can resolve this conflict." Clients gain the most out of a referral when they commit themselves to changing something about themselves.

INDICATE THE APPROPRIATE HELPING AGENCY. Once you have determined the real client need and gained a commitment to change, it is then time for you with input from the client, to determine the appropriate referral agency. The counselor should evaluate his/her expertise, qualifications, and ability to aid the client. Consider carefully the above-listed items, used in deciding whether or not to refer. If, after careful evaluation, you determine that referral is the most appropriate action to help the client, determine the appropriate referral agency and indicate this to the client. Indicate this clearly, showing the benefits of this helping agency to the client.

EXERCISE III

1. How does identifying what the client wants and clearing up ambiguous statements help in the referral process?

2. Why should client records be reviewed prior to beginning the interview?

3. Why is it important to gain a commitment to change from the client before referring?

OBJECTIVE

Identify four proper procedures to follow when referring clients.

INTRODUCTION

Referring a client to an agency doesn't mean the client will necessarily make the appointment and visit that agency. Also, just sending the client without any amplifying data may cause problems with the client gaining the help he/she needs. There are basically four procedures that, if followed, can head off problems like these.

INFORMATION

PROCEDURES

Step One: Document

As with most client actions in social actions, it is very important to document counselor and client actions. The following procedures will help you insure your documentation is clear and concise, and more importantly, that it communicates the right message to the person you are sending the consult to.

MAKE BEHAVIORAL STATEMENTS OR QUOTE VERBAL RESPONSES. To communicate effectively with the referral resource agency, place your description of the client's problems and life situation in *behavioral terms*. This is the simplest, clearest language you can use. There is no room for interpretation, since you have not drawn conclusions or abstractions from the behavior. The referral resource, then, gets the same view of the client's behavior that you do with minimum interpretation. For example, instead of saying "John's anxiety about his maternal identification," say "John's voice begins to quiver, his hands shake, and he looks down at the floor when he talks about his dislike of his father and fear that he may be 'too much like' his mother."

DON'T LABEL. Because labels mean different things to different people, they communicate imprecise images to the receiver of the communication. Labels often lead to stereotyped images of what the person or problem is like which, in turn, lead to stereotyped ways of treating the problems. It is far better to describe the behavior than label it. When you describe behavior, the receiver of the writing will have a clear picture of what the problem is. Since you are not qualified to label a client a "paranoid schizophrenic," if you do, it can get you in trouble legally and/or professionally. Psychiatrists will not look favorably upon your "diagnosis." They will, however, use the observed behavior you document in your consult, and have you be the extension of their eyes and ears. The surest way to cut off good working relationships between you and the mental health clinic is to give your clients psychiatric labels in your consults.

Step Two: Escort in Some Situations

In some situations, the client should be escorted to the helping agency. If the client is under such stress that he/she shows signs of mental illness (see Mental Health Terminology) which indicate the person needs help in getting to the referral resource, escort the person. During times of severe crisis to the client, it may be best to escort. If the person seems disoriented, escort. You must be the judge of which situations call for escorting the person. Base your decision on allowing the client to take maximum responsibility for his/her getting to the referral agency, and still getting him/her there. Don't ask a client to do something over his/her head, however.

Step Three: If Possible, Get the Client to Call in Your Presence

The reason you want the client to make his/her own appointment (if possible) is that this action helps the client take responsibility for the referral. By having the client take as much responsibility as possible for selecting and arranging the referral appointment, you'll increase the probability that the client will get to the appointment and, most importantly, get something out of the referral. Imagine the case in which the client is badgered into saying, "Yeah, I know I ought to go see a marriage counselor . . . but . . . . Yeah, sure . . . I'll go." Chances are that this "parent" contract will not work and , if the client actually arrives at the helping agency, he/she will not get anything out of the referral, and then will blame the counselor for making the wrong choice of referral agency. By increasing the client's role in deciding upon and making the appointment, you increase the client's investment in, and ownership of getting something out of the referral. When you refer, remember to refer to only one agency at a time. This will prevent client confusion which results from making several referrals at one time. Making one referral at a time is especially important if the client is in a crisis situation. In crisis situations, people tend to become confused easily because of anxiety blocking parts of their perception. Anxiety can give a type of "tunnel vision" to your clients. Under these conditions, more than one referral at a time may confuse your client even more. It is far better to give the client a clear idea of why he/she is going to, and what he/she will gain from the particular referral. This is easier to do if you make only one referral at a time.

Step Four: Followup

The reason AFR 30-2, Social Actions Program, requires followup for all referrals is because of the importance of followup in the referral process. This area is often the weakest area in the referral process, yet is the most important. Good followup leads a credible counseling service by pulling all helping agencies into a tight-knit team effort to help the client. If you are interested in the client, and not "buck-passing," you can show this concern by effective followup. You need feedback from the helping agency to help you understand what actions have been taken by that agency, and what actions you need to take when the client returns to your office. Without proper feedback, you will be operating in a knowledge vacuum. The interchange between you and the referral resource can be invaluable in gaining an understanding of the client in minimum time, and determining the client's needs in the shortest possible time. It is often helpful to close the feedback loop by asking information from the referral agency, and asking the client what the referral meant to him/her. This gives you data on how the client perceived the help, what about it was meaningful, what kind of distortions exist between the client's and the agency's reality, as well as feedback on how well certain people at that agency helped your client. The followup data will better enable you to assist your client with continuity of effort and to do so in the most efficient way. If you update your referral roster with names of people and whether or not they received good reports, you should begin to do a better job of selecting the best referral agency, and person at that agency.

EXERCISE IV

1. What are the four steps to making a referral? 570

2. What must be contained in the referral/consult word picture you send to the referral agency?

3. Why is followup of a referral so important?

SUMMARY

The referral decision is often a difficult one, but the potential benefits to your client are great. If you decide a referral is the best way to help your client, remember the very important steps to follow in making and following up the referral. When you receive feedback that a referral agency is good or bad, check it out. Then add this new information to your referral list so that the next time you'll make even better referrals.

ANSWERS TO EXERCISES

EXERCISE I

Answer 1. Referral agencies might be identified on your base by brainstorming with (a) education classes, DAAC Committee, or a rehabilitation group; (b) you can also consult the base or civilian phone directories; (c) ask around at local Mental Health Centers, public welfare offices, or interagency counsel.

Answer 2. The idea of checking out an agency is very important so that you, as a referral agent, can validate that the agency will be able to provide a service that it says it can; how effective that service is; and if it's what the client needs to assist in rehabilitation.

Answer 3. Selecting the best referral agency for your client will enable the client to satisfy his problems quicker, thereby facilitating the rehabilitation process.

EXERCISE II

Answer 1. Knowing your limitations as a counselor is a necessary item in the counseling situation, because tackling a problem that is beyond our scope of adequacy and training can do more harm than good.

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Exercise II - Continued

Answer 2. Two examples of times when a need for extra help is the cause for referral are: (a) the client whose financial situation is a mess may need legal or finance office, or even counseling by the first sergeant. (b) Referral of the client to central alcohol treatment center for extra help for a client whose involvement with alcohol is of such a serious nature that his/her rehabilitation process need a temporary concentrated effort that can be provided by the experts at the alcohol treatment centers.

Answer 3. Two examples of another getting through better are: (a) The first sergeant might be able to get through to a client with some attitude problems with wall-to-wall counseling. (b) A Mental Health technician might be able to get through with an individual suffering from deep depression.

Answer 4. Social Action's counselors are mainly involved in short-term counseling. In the event it is decided that a client will need long-term service, for whatever the reason, then a referral to a qualified agency in that ares should be considered.

EXERCISE III

Answer 1. By asking what the client wants, the counselor may become more aware of how the client sees his/her problems and the kinds of solutions that might be acceptable for the client clearing up ambiguous responses. Help the referral process by helping the client and you to come to a mutual decision concerning the client's needs.

Answer 2. Records should be reviewed, before the client comes, with an eye for possible ways in which you may be able to help the client.

Answer 3. It is important to try to gain a commitment to change from the client because, if he/she commits himself/herself to changing, the client will gain far more from the referral.

EXERCISE IV

Answer 1. The consult word picture sent to the referral agency must be in simple, clear language. Make behavioral statements or quote verbal responses and do not label.

Answer 2. Followup is very important because the feedback you get from the helping agency will enable you to be knowledgeable of what the agency did for the client, what actions you need to take when the client returns to your office, and if the agency can remain a valuable tool for your office to use in assisting clients with continuity of effort and in a most efficient way.

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PART II - TEACHING GUIDE

INTRODUCTION (10 Minutes)

ATTENTION

Drug and alcohol abuse is viewed as a symptom, directed at the goal of actualizing some value.

a. These values provide a matrix of gains or rewards, punishments, and possibilities.

b. A drug or alcohol abuser is coping with his/her world in a way that , at the moment, seems most likely to satisfy his/her deeply-felt needs; e.g., security, experimentation, etc.

MOTIVATION

One of the main concerns in Social Actions is behavioral reorientation (Phase IV), in addition to providing individual and group counseling sessions.

a. It is not possible to effectively alter or modify

behavior without first understanding the reasons for that behavior.

b. To effectively prevent drug/alcohol abuse behavior, we must understand the needs of the clients (plus or minus) to assist them to develop coping behaviors which the clients accept as more effective for handling the "needs or wants" (the problems).

c. It is a poor technique to directly attack a behavior without any effort to understand <u>what the behavior is doing</u> for the person (the "gains" or "rewards" he/she seeks).

OVERVIEW

1. Read the lesson objectives to the class.
2. Develop the lesson chronology.

BODY (2 Hours 40 Minutes)

PRESENTATION

4a. CRITERION OBJCTIVE: Identify three primary factors which shape a person's values.

1. Explain that some reasons people abuse drugs and alcohol are pleasure, peer-pressure, escape, challenge, dependence, etc.

a. There are no drug or alcohol problems, but there are people problems and coping problems which are sometimes treated with self-prescribed drugs.

(1) People problems: These are problems which deal with <u>self</u>.

(a) Estrangement/ alienation.

(b) Low self-esteem.

(c) Meaninglessness.

(d) Inadequate role-identification.

(e) Inadequate self-image.

(2) Coping problems:

These are problems of adjustment.

(a) Difficult or unknown situations.

(b) New or unusual relationship.

(c) New or difficult feelings and emotions.

b. Drug/alcohol abuse is assumed to be a dysfunctional, coping behavior.

c. Drug/alcohol abuse does not provide any new skill or permanent means of value satisfaction.

2. Explain that each of the "causes" of drug/alcohol abuse has to do with personal feelings and reactions resulting from values, not facts.

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a. A value is that which every person, consciously or unconsciously, strives for constantly, with durability, time-consciousness, and intensity.

b. Lack of adequately developed and realizable value systems; lack of opportunity to realize and experience the zest and challenge of youth in more personally satisfying and socially acceptable ways; all combine to produce the temporarily satisfying choice of behavior as drug/alcohol abuse.

c. The crucial question about drug/alcohol abuse revolves around the behavioral effects. Chief concerns include:

(1) First, social use spreads to others by psychic contagion (peer-pressure).

(2) Second, use produces psychosocial disabilities.

(3) Third, abuse produces behavior disorders, defects of judgment, and lack of coordination.

(4) All of these involve the welfare of others.

3. Identify three primary factors which shape a person's values.

a. If we are going to effectively deal with drug/alcohol abuse, we must deal with the following.

(1) Attitudes, which presage any and all behaviors.

(2) Alternatives, which provide a wide choice of behavior which will satisfy a basic need or want.

(3) Decision-making skills, so that every person can learn how to make decisions which will enhance him/her, rather than deprive or harm him/her.

b. These three factors comprise the process of value clarification.

PRESENTATION

4b. CRITERION OBJECTIVE: Identify the eight basic needs of man and the personal considerations which affect his selection of behavior patterns to satisfy these needs.

1. Explain that every behavior known to man is the result of deprivations or enhancements in one or more of eight basic needs or wants.

2. Identify the eight basic needs and wants of man (findings of Dr Harold Laswell, Yale University, 30 years of research).

a. Affection - friendship, love, fondness, and loyalty.

b. Respect - honor, courtesy, recognition, and admiration.

c. Well-being - health, happiness, and contentment.

d. Power - decision-making, influence, authority, and leadership.

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e. Enlightenment - knowledge, education, learning, and understanding.

f. Skill - ability, training, talent, and ability.

g. Wealth - food, shelter, income, working, and property.

h. Rectitude - responsibility, honesty, justice, fair play, and trust.

3. Explain that if a person cannot satisfy his/her basic needs in normal (socially-acceptable) ways, a person still has the need.

4. Explain that each person strives to fulfill his/her values by engaging in such behavior as he/she consciously or subconsciously feels will best (and quickly) fulfill his/her goals.

a. To accomplish these ends, he/she makes a series of choices between alternative coping behaviors -- functional and dysfunctional.

b. The person optimizes the chances of actualizing his/her values according to his/her perception of the available choices or alternatives.

5. Explain that the degree to which an individual decides to engage in dysfunctional coping behavior is assumed to be directly related to his/her inability or unwillingness to reach valued goals by more functional means.

a. A person does not just spontaneously acquire motives for "skill," "rectitude," etc. It is only through a history of selective reinforcement (sequential learning) that one learns what to value, how much to value it, and how to reach the desired goals.

b. When a person feels deprived of one or more of the eight needs and wants, he/she copes with his/her needs and

wants by dysfunctional behavior; e.g., shouting, lying, drug/alcohol abuse, refusal to adhere to rules, cheating, withdrawal, etc.

6. Summarize, by discussing the value deprivation - enhancement continuum. It shows the functional and dysfunctional behavior with the eight needs and wants (see Attachment 1).

a. There are four areas within the continuum.

(1) Movements toward pathology.

(2) Low value status.

(3) Movement toward potential.

(4) Value category.

b. The purpose is to show the total value of the risk or gain to be obtained from a behavior; i.e., movement towards pathology or full potential.

PRESENTATION

4c. CRITERION OBJECTIVE: Identify the seven criteria by which a true value can be identified.

1. Explain that each person has attitudes and makes decisions (consciously or subconsciously) to act on them toward pathology or fulfillment, but must know whether or not his/her goal is a true value.

2. Explain that Sidney B. Simon, Ph.D., University of Massachusetts, has defined seven criteria which differentiate between a true value and a "value indicator" (non-value).

a. A value indicator meets fewer of the seven criteria. Examples of value indicators include attitudes, opinions, beliefs, feelings, morals, and aspirations.

b. Value indicators become values when they meet all seven criteria.

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3. State the seven criteria for values clarification. The value must be:

a. Chosen freely.

b. Chosen from alternatives.

c. Chosen after careful thought.

d. A prized and cherished choice.

e. Publicly affirmed.

f. A choice that is acted upon.

g. A choice which is acted upon consistently and regularly.

4. Emphasize that from the seven listed criteria the vital importance of the third primary factor in values clarification -- decision-making -- can be readily seen.

EVALUATION

1. What are the three primary factors which shape a person's values?

2. How do values determine behavior patterns in the satisfaction of needs?

3. Which primary factor, which shapes values, is indicated most strongly by the seven criteria used to identify true values?

APPLICATION

1. Direct the students to their small groups.

2. Conduct at least one of the three approved exercises.

(see Attachment 2)

CONCLUSION (10 Minutes)

SUMMARY

1. We have examined the values-clarification process of attitude (prize), alternatives (choice), and decision-making (act), so that we, as counselors in Social Actions, can understand that what appears to be dysfunctional behavior is a fact that is caused by

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the "eight needs or wants." When these needs or wants are not achieved in a functional way, the overt behavior reflects this, since the need still has to be fulfilled.

2. Examination of the values-clarification process allows us to realize that, through the alternative (choice) system and a decision-making (act) process, the drug/alcohol abuser can turn dysfunctional behavior into fulfilling behavior and still fulfill his/her "needs and wants." Our primary emphasis in counseling is dealing with the values, rather than the causes, of drug/alcohol abuse.

3. We have looked at the criteria which must be fulfilled if the attitude is to be dealt with as a "value indicator" or a "true value."

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REMOTIVATION

Our constant efforts in counseling drug/alcohol abusers will revolve around the values of these clients. By understanding how values are formed and what constitutes a "true value" for a client, we also become more "in touch" with our own values. Since counseling depends on knowing ourselves as much as possible, the values-clarification process is one we can constantly employ to re-examine ourselves and thus improve our counseling relationships.

ASSIGNMENT

Give complementary technical training assignment, when appropriate.

VALUE DEPRIVATION-ENHANCEMENT CONTINUUM

MOVEMENT TOWARD PATHOLOGY		LOW-VALUE STATUS	MOVEMENT TOWARD FULL POTENTIAL		VALUE CATEGORY
Alienation Hatred	Fear Suspicion	Indifference Withdrawal	Caring Acceptance	Trust Intimacy	AFFECTION
Degradation Disintegration	Discrimination Segregation	Isolation Inferiority	Self-Esteem Identity	Esteem for Others Integration	RESPECT
Incompetency Failure	Non-achievement Inadequacy	Underachievement Awkwardness	Achievement Adequacy	Competency Success	SKILL
Distortion Deception	Confusion Misunderstanding	Uncertainty Ambiguity	Awareness Openness	Empathy Sharing	ENLIGHTENMENT
Resistance Aggression	Submission Coercion	Conformity Dependence	Self-Direction Influence	Cooperation Participation	POWER
Indigence Destitution	Non-productivity Marginal	Maintenance Subsistence	Productivity Creativity	Abundance Affluence	WEALTH
Anxiety Illness	Irritation Frustration	Existence Unhappiness	Hope Joy	Contentment Health	WELL-BEING
Malice Depravity	Irresponsibility Unscrupulousness	Apathy Negligence	Responsibility Consideration	Integrity Altruism	RECTITUDE

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ATTACHMENT 1

VALUES-CLARIFICATION EXERCISES

I. Meditation on Me. (Clarification of self-image and determination of what part(s) of that self-image is (are) most valued.

1. Pre-briefing. Explain to the students that in this exercise they are going to explore their personal values as they apply to their self-image. Explain that they are to relax as much as possible, and allow thoughts of themselves to drift into their minds. Each student will have in his/her possession eight pieces of paper, and as a thought or phrase comes to mind, pertaining to his/her self-image, he/she is to open his/her eyes and record that thought on a piece of paper, and then close his/her eyes and relax and repeat the process until he/she has used all eight pieces of paper. At the conclusion of the exercise, students will be asked to put the eight items in priority order of importance.

2. Conduct exercise.

a. Issue papers to each student (eight each).

b. Tell students to close their eyes, relax, and let their minds play with words, or phrases, which describe themselves.

c. Tell students to open their eyes, write one word or phrase which came to mind during the meditation on one piece of paper. (Variation: Allow three to five minutes of continuous meditation, and have students fill out all pieces of paper at one time.)

d. Repeat steps "b" and "c" until all students have filled out all eight pieces of paper.

e. At this point, students have indicated what they PRIZE. Identify and clarify this to all students.

f. Have each student arrange the eight pieces of paper in order of how much he/she values each (most value is one; least is eight).

g. At this point, the students have exercised their CHOICE. Identify and clarify this to all students.

h. Allow each student to announce his/her values to the group in the order of their priority, most-valued to least-valued.

ATTACHMENT 2

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1. At this point, the students have exercised the ACT/AFFIRM portion of the values-clarification process. Identify and clarify this to all students.

3. Closure/Debriefing. Discuss the process of values clarification as it occurred in the group. Identify and emphasize the three factors involved in values clarification, prize, choice, and act/affirm. Make other process comments, as appropriate; i.e., listening skills demonstrated, acceptance of others, etc. Stress the fact that values are flexible and subject to change. Each person has the right and ability to examine and alter his/her personal values. Stress that we have no right to impose our values on others who are unwilling or unable to accept those values. Cite examples, if appropriate.

II. Wallet Exercise. (This exercise demonstrates that personal belongings, such as cards and pictures carried in a wallet, may reveal what we value or prize.)

1. Pre-briefing. Explain to the students that we often carry indicators of our values on our person; and, as an extension of that, the cars we drive or where we live may be indicative of our values. In this exercise, we will be sharing three items from our wallets which we feel give adequate representation of our values.

2. Conduct exercise.

a. Have students form dyads or triads, whichever is most convenient for the group size.

b. Have each student remove three items from his/her wallet which will communicate his/her values, what he/she feels is important in his/her life.

c. When each student has selected three items, have students in the group exchange their items, without talking. Instruct the students to concentrate on those items received and attempt to anticipate the value of each item to the giver, what has been communicated by each object, individually and collectively.

d. Instruct the owners of articles to share the value of each item with the recipients. During the portion of the exercise, there is no feedback to the owner from the recipient.

e. Instruct the recipients to share with the owners how they had initially construed the value attached to each item.

f. Allow for discussion of the exercise among the two-/three-person groups and, finally, in the larger group.

3. Closure/Debriefing. Discuss the prize-choice-act/affirm process of the values-clarification process as it occurred in this exercise. Make other process comments, as appropriate.

III. Things I Love to Do. This exercise focuses the individual's attention on things he/she enjoys doing. There is no need to rank-order the activities. In the process of the exercise, the students will become aware of activities (involving risk, similar to activities enjoyed by their parents, enjoyed alone or with someone, recently-adapted, which may be dropped in the near future).

1. Pre-briefing. Inform the students that they will be listing activities they enjoy (20 different activities). Each student will need pencil and paper, and there are no "right" or "wrong" answers. When the lists have been completed and coded, each student will study his/her own list and be asked to make some personal judgments concerning his/her list.

2. Conduct exercise.

a. Instruct each student to take a pencil and paper and list twenty enjoyable activities. The activities can be listed alone or with others.

b. Allow the students approximately five to ten minutes to complete lists.

c. After completion of the lists, identify that the students have accomplished the PRIZE factor in the values-clarification process.

d. Instruct students to code their lists according to the following scheme:

(1) Put an "R" beside any item involving risk. The risk may be physical, intellectual, or emotional.

(2) Put an "F," "M," or "FM" beside any item your mother, father, or both parents may have had on a list if they had made one when they were your age.

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(3) Place a "P" or an "A" next to each item. "P" identifies activities which you do with other people, and "A" identifies activities you prefer to do alone.

(4) Place a + (plus) beside any item which would not have been on your list five years ago.

(5) Place a - (minus) next to any item which you think will not be on your list five years from now.

(6) Go through your list and identify the approximate date you last engaged in that activity.

e. Instruct students to study their lists and coding and consider the following questions?

(1) What does your list look like?

(2) Can you identify any patterns in the things you love to do?

(3) Did you learn something new about yourself?

(4) Are there some things you are pleased with?

(5) Are there some things you would like to change?

(6) How might you go about changing things?

(7) Are there some things you like to do which you have not done lately? Why? What could you do about this?

f. At this point, the students have exercised the CHOICE aspect of values clarification. Identify this and clarify to all students.

g. Promote discussion of the exercise and personal lists. Emphasize the completion of the values-clarification process through public affirmation of values.

3. Conclusion/Debriefing.

NOTE: Other value clarification exercises may be found in Pfeiffer and Jones publications (Structured Experiences for Human Relations Training and The Annual Facilitator's Handbook) and in Values Clarification, A Handbook of Practical Strategies for Teachers and

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Students by S. B. Simon, L. W. Howe, and Howard Kirschenbaum. Inform students of the availability of these resources in the Department of Social Actions Training library. Additionally, advise students that this exercise has been a demonstration of facilitation of values clarification exercises required by the group facilitation lesson plan.

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STUDY GUIDE

3ALR734308/3OLR7361B/3OZR7364B—III-4-20

Technical Training

Drug and Alcohol Abuse Control

VALUES CLARIFICATION

June 1977

3250th TECHNICAL TRAINING WING
3290th Technical Training Group
Lackland Air Force Base, Texas

Designed for ATC Course Use
DO NOT USE ON THE JOB

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PURPOSE

The purpose of this study guide is to bring into your awareness the way in which a person's values are shaped, and what a true value is along with the criteria used to determine a true value versus a value indicator.

As a result of reading this study guide, you will be able to understand the three primary factors which constitute the procedures a person goes through to decide what is of value to him/her. Once the procedures have been identified, people become aware of how their values will either fulfill their needs in a functional or dysfunctional manner. People will always fulfill their needs, and this can be observed behaviorally through actions. There are seven criteria which must be fulfilled if a person's values are true values or value indicators. Once people become aware that their behavior acts out their value system, if their behavior is dysfunctional, they may realize that their values may not be true values, but rather value indicators. Thus, people's dysfunctional behavior (e.g., drug/alcohol abuse) can be changed to be more functional to fulfill their needs through the values clarification process.

The specific learning objectives associated with each major section of the study guide will lead off the applicable section.

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Social Actions Training Branch
Lackland Air Force Base, Texas 78236

SG 3ALR73430B/3OLR7361B/3OZR7364B—III-4-20
15 June 1977

FACTORS SHAPING VALUES

OBJECTIVE

Identify three primary factors that shape a person's values.

INTRODUCTION

People find out what their real values are by determining how they invest themselves and their resources, such as their time, energy, and money. Values represent self-investment. Personality disorganization often stems from a conflict between values. For example, when a client invests him/herself emotionally and behaviorally in two patterns of behavior which conflict with one another, an inner conflict develops. For instance, John Jones finds himself heavily invested emotionally in both his work and his family; he is uneasy, both when he spends the amount of time he thinks he should spend to do his work well, and when he spends leisure hours with his family. A personal battle is going on between these two values and John, himself, seems to be the loser. He senses that he has unresolved inner conflicts. The counselor can help John bring his values to the surface. When values are surfaced, priorities can be established. Priorities can be shared with both his family and his work and, thus, this inner conflict can be resolved.

INFORMATION

DEFINITION OF A TRUE VALUE

A true value is that which every person, consciously or unconsciously, strives for constantly, with durability, time-consciousness and intensity.

THREE PRIMARY FACTORS WHICH SHAPE A PERSON'S VALUES

Attitudes

Another name for this is the "prize." This is a disposition based on feelings or convictions. This idea of a value as being something of worth points to a definition of value in terms of that which enhances human development. Each person discovers what his/her values are as he/she experiences life.

Supersedes SG 3ALR73430B/3OLR7361B/3OZR7364B—III-4-20, dated April 1977

Alternatives

Another name for this is "choice." In philosopher Stare's terms, this is a choice from the "possibilities" available to the individual. If the choice made by the client is unattainable, the choice is unrealistic. The choice must be within the realm of possibilities for the client.

Decision-Making Skills

Another name for this is "action." This is the crucial stage for many individuals. Some people are afraid to take stock of themselves because they know, however subconsciously, that if they do act they will have to change. If they act, they will have to surrender comfortable (but unproductive) patterns of living, and work more diligently. If they are committed to action, they suffer the pain of loss if their commitment does not work out. If they act, they must acquire skills needed to live more effectively. Making a decision, acting, and being committed to that action cause many consequences — some good, some uncomfortable, some known, some unknown. Many people fear the unknown and prefer living in the "status quo" among safe though unproductive behavior. Thus, values clarification is a methodology or process. Through it, we help people discover what choices their behavior, their feelings, and their thoughts have made. Additionally, the values clarification process identifies these choices as being continual, since they are acted upon throughout people's lives.

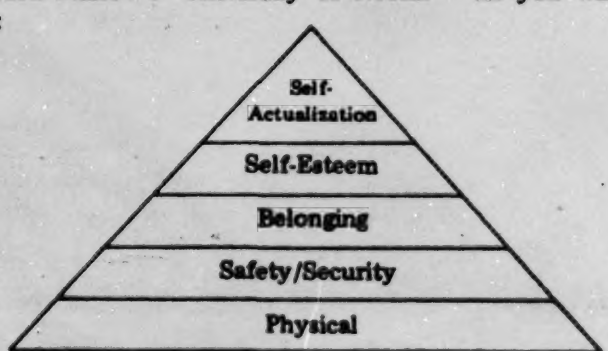
BASIC NEEDS AND SELECTION OF BEHAVIORS TO MEET NEEDS

OBJECTIVE

Identify the eight basic needs of man and the personal considerations which affect his/her selection of behavior patterns to satisfy these needs.

INTRODUCTION

Dr. Harold Lasweil, a Yale University professor, researched value clarification for over 30 years. He expanded Maslow's "Hierarchy of Needs." As you will remember, Maslow's needs are as follows:



Dr. Laswell took these five basic needs and expanded them to include the behaviors associated with them. Thus, when a person feels deprived of one or more of these basic needs, the person copes with his/her needs and wants by either dysfunctional or functional behavior. Examples of dysfunctional behavior are cheating, lying, and alcohol and drug abuse. All functional behavior is caused by our needs, Dr. Laswell says. Thus, as counselors, we have a need to keep this central feature, needs, of value clarification firmly in mind, so that we can understand the reason for dysfunctional behavior.

INFORMATION

EIGHT BASIC NEEDS OF MAN

Each of the eight basic needs identified by Dr. Laswell affects people's behavior patterns by causing dysfunctional behavior if the need is not satisfied. Examples of the dysfunctional behavior caused when the need is unsatisfied, and the functional behavior present when the needs are met are listed below.

Affection

Tender attachment; i.e., love, goodwill. Behavioral dysfunctions of this need are fear, suspicion, hatred, and alienation. People with this need deficit have a value clarification problem, since they would like to be accepting, trusting and caring.

Respect

Consideration, regard, interest. Behavioral dysfunctions, when this need is lacking, include: isolation, inferiority, degradation, etc. The value clarification problem for people arises when they desire self-esteem, identity and integration.

Skill

Knowledge, ability to use your knowledge effectively in performance. Behavior dysfunctions of this need include: incompetency, failure, and nonachievement. People will have a value clarification problem, since they would like to be competent, achievers, and successful.

Enlightenment

Gaining full comprehension of problems involved. Behavioral dysfunctions present when this need is lacking are confusion, deception, and distortion. People move toward full potential with awareness, openness, and sharing.

Power

Control, influence, prestige. Behavior dysfunctions present when this need is absent include submission, resistance, and coercion. People move toward full potential with cooperation, influence, and participation.

Wealth

Welfare, happiness, material success. Behavioral dysfunctions of this need include indigence, destitution, and nonproductivity. People move toward full potential with productivity, creativity, and abundance.

Well-Being

A condition characterized by happiness, health, prosperity, etc. Behavioral dysfunctions present when this need is not met include: anxiety, illness, frustration, etc. People move toward full potential with hope, health, and contentment.

Rectitude

Adherence to a sense of righteousness; sense of justice. Behavioral dysfunctions of this need include malice, irresponsibility, and unscrupulousness. People move toward full potential with integrity, consideration, and responsibility.

HOW THE EIGHT BASIC NEEDS AFFECT BEHAVIOR PATTERNS

Through an analysis of the eight needs, we can see that if a person cannot satisfy his/her needs in socially-acceptable ways, the person will fulfill the need in a dysfunctional way. Thus, people strive to fulfill their needs by engaging in such behavior as they consciously or subconsciously feel will quickly and best fulfill their goals.

People do not just spontaneously acquire motives for "skill," "rectitude," or other needs. It is only through a history of selective reinforcement (sequential learning) that a person learns what to value, *how much* to value it, and *how to reach* desired goals. Thus, when people feel deprived of one or more of the eight basic needs and wants, they may cope with their needs and wants by dysfunctional behavior.

CRITERIA FOR IDENTIFYING A TRUE VALUE

OBJECTIVE

Identify the seven criteria by which a true value can be identified.

INTRODUCTION

Dr. Sidney Simon of the University of Massachusetts, has defined seven criteria which differentiate between a true value and a value indicator. Basically, when a person's "prize" does not meet all seven criteria outlined below, then that "prize" is a value indicator. Value indicators such as beliefs, feelings, opinions, etc., become true values when they meet all seven of the following criteria.

CHOOSING FREELY

The individual must freely make his/her own decisions about drinking, rather than having those decisions forced on him/her. This would include peer pressure. Since one must live with one's decision, it must be one's own decisions to be considered of personal value.

CHOOSING FROM AMONG ALTERNATIVES

All alternatives must be considered when making a decision about alcohol use. This includes whether to drink or not to drink, how much to drink, what to drink, etc.

CHOOSING AFTER THOUGHTFUL CONSIDERATION OF THE CONSEQUENCES OR BENEFITS OF EACH ALTERNATIVE

Telling yourself that you are willing to accept the consequences as well as the benefits of your decision to drink or not is a tremendous step toward maturity. This could possibly include loss of friends, gaining new friends, personal fulfillment, moments of relaxation, new position of status, traffic violations, accidents, and increased or decreased respect.

PRIZING AND CHERISHING

How comfortable people feel in living with their decisions is a measure of self-confidence. This does not prevent them from changing an earlier decision. Neither is it encouraging them to evangelize or broadcast their decision about alcohol use. Prizing and cherishing is living with the decision they have made.

AFFIRMING

When a person refuses another drink on "the next round" and knows why he/she did so, then that person is affirming his/her value to him/herself

ACTING UPON CHOICES

As the value is forming, it is reinforced through consistent decisions which become more natural acts than forced acts. The friends a person chooses will help reinforce

the decision, rather than challenge his/her decision. The places a person visits will generally not conflict with his/her life style, but rather support it. Time, money, and energy will be devoted to the reinforcement of the decision.

REPEATING

As a person's value becomes a part of his/her life style, people observing this person will see the decision continuously expressed.

All three factors of the value clarification process are involved in this classification; namely: *prize*, *choice*, and *action*. The sense of performance is also indicated in this classification. Thus, temporary pleasures induced by alcohol or drugs, although real, fail to meet the criteria for a true value.

SUMMARY

As Social Actions counselors, using the value clarification process allows us to understand that what appears to be dysfunctional behavior on the part of the client may, in fact, be caused by a dysfunctional fulfillment of needs. When these needs or wants are not achieved in a functional way, the overt behavior reflects this, since the client's needs still must be fulfilled. Thus, the value clarification process allows us to realize that through the choice system and a decision-making process, drug/alcohol abusers can turn dysfunctional behavior into functional behavior and still meet their needs and wants. Our primary emphasis in counseling is dealing with true values, rather than the actual abuse of drug/alcohol, by using the process of value clarification.

REFERENCES

1. Simon, Sidney B. and Howe, Leland W., *Values Clarification*, New York, Hard Publishing Company, 1972.

2. Simon, Sidney B. and Raths, Louis E., *Values and Teaching*, Columbus, Ohio, Charles E. Merrill Publishing Company, 1966.

3. Weiss, Paul and Weiss, Jonathan, *Right and Wrong*, New York, Basic Books Inc, 1967.

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PART II - TEACHING GUIDE

INTRODUCTION (5 Minutes)

ATTENTION

The most effective way to get a person off drugs or alcohol and keep him/her off is to identify and get him/her involved in a viable alternative.

MOTIVATION

1. The Second Report of the National Commission on Marijuana and Drug Abuse recommends that drug use prevention strategy, rather than concentrating on resources and efforts in persuading or "educating" people not to use drugs, emphasize alternative means of obtaining what users seek from drugs; means that are <u>better</u> for the user and better for society!

2. The aim of this program, called viable alternatives or alternative pursuits, should be to foster and instill the necessary skills for coping with the problems of living, particularly the life concerns of adolescents. We learned in the Values Clarification Unit that there are no drug problems, but rather there are people and coping problems, when individuals use self-prescribed drugs to deal with problems.

3. Since our job in Social Actions is not only to counsel but to educate and administer programs and policies concerning drug/alcohol abuse control, the necessity of understanding the alternative pursuits concept in drug/alcohol abuse will allow us to effectively offer appropriate alternatives to:

a. Clients already in our rehabilitation programs.

b. Base personnel, who are seeking better self-awareness and pursuits but not abusing drugs. Thus, the prevention aspect of our base-level education becomes a realistic concept to all people with whom we come in contact.

4. All too often, the viable alternatives concept has been a task of creating lists of hobbies without a clear understanding of the objectives and guidelines underlying this concept. The previous methodology increased alienation of young people, since the old viable alternatives listing of hobbies usually never took into consideration young people's problems from their point of view, but rather the viewpoint of those in positions of authority. The listing of hobbies presumed that drug use was a disease and drug education a vaccination. Thus, young people need to be offered a wide variety of programs attempting to offer help and support, because they run a wide range of values, class backgrounds, subcultures, etc.

OVERVIEW

1. Cover the lesson objectives with the class.

2. Discuss lesson chronology.

a. Definition of viable alternatives.

b. Three objectives of the alternatives approach and eight factors to consider when applying this approach.

c. Realities to keep in mind when dealing with clients' acceptance of viable alternatives.

d. Implementation of the viable alternatives concept to individual clients, as well as base-wide programs.

TRANSITION

So that everyone will understand what is meant by viable alternatives, let's start by defining the term.

BODY (2 Hours 45 Minutes)

PRESENTATION

5a. CRITERION OBJECTIVE: Identify the three major objectives of the viable alternatives approach to drug abuse prevention and rehabilitation and eight factors to consider before using this approach.

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1. Define viable alternatives.

a. The word "viable" implies a workable, sustainable condition.

b. Alternatives.

(1) Do not mean substitutes, but invervention.

(a) Not all people are susceptible.

(b) Concentrate on those who show early symptoms.

(c) Substitutes are something which takes the place of something else.

(2) Viable alternatives are often referred to as "alternative pursuits."

c. Alternatives to drugs/alcohol are defined as: "Those constructive and viable attitudes, values, orientations, experiences, life styles, opportunities, activities, pursuits, and progress which can prevent significant drug/alcohol abuse by providing greater satisfaction than can drugs."

2. There are three major objectives of the viable alternatives approach to drug abuse.

a. Minimize adverse consequences of use and escalation to stronger or more dangerous drugs. "Drug abuse is a response to an experience deficiency. We must give attention to those relevant factors creating that deficiency. Our institutions are not providing

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an adequate context for the kinds of exploration and experience THAT MEET DEEP HUMAN NEEDS. Therefore, they sustain some of the underlying motives for drug use." (Allan Y. Cohen, Ph.D., Alternative Pursuits, page 3)

b. Maximize involvement in:

(1) Life experiences.

(2) Responsible use of chemical (toxic) agents.

c. Produce new state of consciousness for the user or non-user and improve his/her sense of worth.

3. Identify eight factors which must be considered when applying the alternative pursuits approach.

a. Individual needs (Maslow's hierarchy).

(1) Basic survival need.

(2) Security.

(3) Belonging.

(4) Self-esteem (others).] Growth Needs

(5) Self-actualization.]

b. Value systems/orientation.

(1) Prize.

(2) Choice.

(3) Action.

c. Level of satisfaction derived from the abused substance

will affect a decision about an alternative.

(1) Abuser is more likely to accept an alternative when the level of satisfaction from substance abuse has peaked and is declining or remaining constant.

(2) Poly-drug abuse may complicate this situation, since the user has the ability to vary his/her drug use and resultant satisfactions (euphoria).

d. The level of experience with the drug substance will affect the alternative selected.

(1) Minimal drug involvement requires less dramatic alternatives applications; i.e., experimenters will most likely be open to suggestion to abstain from use, whereas addicts or heavy abusers may require change of environment, peers, work environment, etc.

(2) Individual motivations for continued or discontinued substance abuse will also play a great part in determining the effectiveness of alternatives proposed.

e. Explain that the type of drug abused is often a key to the motivation of the abuser.

(1) Depressant substances for "escapism," "to forget."

(2) Stimulants for stimulation of senses, endurance.

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(3) Hallucinogens for "consciousness expansion," "mystical experiences."

f. Explain that a lack of awareness by commanders and supervisors acts as a barrier to alternatives.

(1) Specialists do not welcome change. Change attacks tradition and historical precedents upon which the specialist has earned his/her position.

(2) The communication gap or generation gap is extremely real. Unless we discuss our differences, we are unable to surface problems which can be solved. Answers are readily available for most problems which are well stated.

g. Alternatives must be viable to the drug/alcohol user.

(1) Culture.

(2) Value systems.

(3) Life style.

h. Alternatives should <u>not</u> be temporary in nature.

(1) Temporary alternatives encourage recidivism.

(2) ". . . Give a man a fish and you have solved an immediate problem. Teach a man to fish and you have solved a life problem. . ."

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EVALUATION

1. What are the three objectives of the alternatives approach to drug abuse prevention and rehabilitation?

2. What factors should be considered prior to using the alternatives approach?

PRESENTATION

5b. CRITERION OBJECTIVE: Identify the major factors which affect client acceptance of alternatives.

1. Explain that use of mood-altering substances is usually pleasureable.

    a. People use drugs to "feel better" or "feel good."

    b. People abuse drugs due to personal deficiencies; e.g., coping mechanisms.

2. Emphasize that people start and may continue use (abuse) of drugs because they want to do so, not because of some intrinsic nature of the drug.

    a. Prize, choice, action.

    b. Free will, conscious decision.

3. Explain that drugs do not compel behavior.

    a. May lessen inhibitions or interfere with logical thinking; therefore, allowing unusual behavior.

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b. Drugs, by themselves, do not produce actions by the person.

c. Ultimately, the person, even in the most physically-addicted cases, does have free will to choose to use or not use drugs.

4. Explain that psychological dependence results when the drug effect fills a need or is a "people substitute." Any activity or agent which gives pleasure or relieves discomfort may be associated with psychological dependence.

5. Emphasize that drug users are not necessarily immature, immoral, irresponsible, or socially disadvantaged.

a. Assumption of immorality involves acceptance of stereotype.

b. We need to have respect for clients.

c. Drug use is a part of the continuum of human existence.

6. Emphasize that all use of illegal or socially-disapproved drugs is not necessarily abuse or addiction.

a. Some legal drugs are abused because they produce physical, psychological, or social damage.

b. Some illegal drugs are used socially without noticeable harm to the individual.

c. Some illegal drugs are not physically addictive. Some are used in such a way as not to cause psychological dependence.

7. Explain that the important factor in many forms of pleasure-seeking (gratification) behavior is the resultant change in the mood or consciousness of the person.

8. Explain that our society appears to stress experience as a prerequisite for maturity. Some drugs are alleged to give experience quickly, painlessly, and effortlessly.

9. Emphasize that individuals do not stop using mood-altering substances or pleasure-seeking behavior until they discover somethin better.

10. Explain that the alternatives to drug abuse are also alternatives to the distresses and discomfort which lead to any self-destructive behavior.

EVALUATION

1. Do drugs compel behavior?

2. Give an example in which an attitude of society contributes to drug abuse.

3. Generally speaking, when does an individual become willing to cease one behavior and adopt another?

PRESENTATION

5c. CRITERION OBJECTIVE: Identify five selection criteria for an alternative pursuit.

1. Describe selection criteria for an alternative pursuit.

a. Must be acceptable to the client.

b. Must be acceptable to the governing society/institution.

c. Must be an attainable objective.

(1) Cost.

(2) Time.

(3) Legality/acceptability.

d. Must offer an opportunity for individual commitment.

e. Must be capable of producing discernable changes toward self, others, and the experience in the client.

2. Emphasize that alternatives do <u>not</u> need to be traditional.

EVALUATION

1. What factors affect the attainability of an alternative pursuit?

2. Should alternatives be traditional?

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PRESENTATION

5d. CRITERION OBJECTIVE: Identify three features that alternative pursuits should possess in order to gain maximum appeal to approving authorities.

1. Explain that alternative pursuits should be cost-effective and be based on sound principles.

a. Be objective.

b. Be prepared to prove your idea wrong, as well as prove it right.

c. Explain the need for thorough research of the concept.

(1) Identify precedents and the outcome.

(2) Identify significant similarities and differences in your proposal and those activities which established the precedent.

(a) Features of the community.

(b) Characteristics of the population to be affected as participants.

(c) Other limiting or encouraging factors.

2. Explain that alternative pursuits which are adopted should complement the desires of the approving authority.

a. Improvement of mission capability.

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b. Improvement of morale.

c. Reduction of expenditures.

d. Improvement of management.

3. Emphasize that alternative pursuit proposals should include provisions for evaluation, in order to measure and report their effectiveness.

a. Explain that ongoing evaluation of the proposal is necessary to insure events are occurring as planned.

(1) Document significant events/lack of programmed reactions.

(2) Keep the established authority informed.

(3) Maintain the planned objectivity.

b. Stress the need for follow-up evaluation.

(1) Successful alternatives are generally permanent. Follow-up establishes that the program has met its objectives.

(2) Alternatives result in discernable changes to self, others, and the experience. Evaluate the positive/negative aspects of the changes and adjust future applications of the concept.

(3) Continued evaluation and reevaluation maintains currency of your programs and dictates changes which may be

necessary because of changes in the society, the environment, or the individuals concerned.

EVALUATION

1. What three features should alternative pursuits possess in order to gain maximum appeal to approving authorities?

2. What types of evaluation should a viable alternative pursuit permit?

APPLICATION

1. Have the students proceed to group room.

2. Provide students a copy of the Viable Alternatives Interview Worksheet and instruct them to read it entirely before commencing the interview. Data revealed in the worksheet is for "here-and-now" application, and not for hypothetical situations. The interview is reality-based, and should provide each student alternatives which he/she may pursue during the remainder of the course.

3. Have students pair off into dyads, where each will act as a "client" and "counselor." Inform students that you will be observing their application of counseling techniques and skills during the interview.

4. For forty minutes, one member of the dyad will be the "counselor," utilizing his/her

worksheet. At the end of this time, the dyads will switch roles. The same procedures will be followed.

5. For this exercise, normally scheduled break-times are waived. Advise students to take ten minutes or shorter after completing the first interview, and then return to the group room to continue. Do not hold groups in session for longer than ninety minutes without a break for each student.

6. If group time remains after completing the Viable Alternatives Worksheets, use it to process the exercise and provide feedback on counseling techniques/ viable alternatives.

CONCLUSION (10 Minutes)

SUMMARY

Review lesson objectives.

a. Objectives of alternatives approach.

b. Factors which affect client acceptance of alternatives.

c. Selection criteria for alternative pursuits.

d. Selling features of alternative proposals to approving authorities.

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REMOTIVATION

1. Viable alternatives can be a meaningful program, not only for the drug/alcohol abuser within our rehabilitation programs, but also for those who are not abusing drugs and still looking for a "high."

2. Our education programs can now be meaningful experiences for our audiences. Their participation, utilizing viable alternative principles we have discussed, can make our education classes come alive for them.

3. So much of this concept depends on your understanding of the objectives and your desire to implement meaningful programs on your bases. This means a lot of coordination and effort. But, the result will be a base population more in tune with alternatives to drug abuse and still experiencing a lasting enjoyment -- chemically-free!

ASSIGNMENT

Give complementary technical training assignment, when appropriate.

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3290 Technical Training Group
Social Actions Training Branch
Lackland Air Force Base, Texas

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30ZR7364B-III-5-4-I
12 May 1976

VIABLE ALTERNATIVES INTERVIEW WORKSHEET

Application

In small groups, each student will select a partner. Each student will complete a Viable Alternatives Interview Worksheet with his/her partner. The interview format presents basic areas which must be discussed. Students are free to expand each area spontaneously to obtain an in-depth understanding of current activities, the dominant value structure and motivations leading to the activities in order to propose, discuss, and reach consensus on alternative pursuits for the client.

Worksheet

1. Using the values clarification concept of (a) prize, (b) choice, and (c) affirm, identify at least three valued activities/interests of your "client."

a. _____

b. _____

c. _____

NOTE: This area will clarify the PRIZE portion of the values clarification process and is an integral part of the viable alternatives process.

2. Identify and reach agreement on the motivations/satisfactions attached to each of the foregoing activities.

ACTIVITY	MOTIVATION/SATISFACTION
a.	_____
	_____
b.	_____

ATTACHMENT 1

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ACTIVITY MOTIVATION/SATISFACTION

c. _____

_____

3. Discuss and eliminate lesser motivations/satisfactions until the "client" selects ONE motive or satisfaction which is of primary importance to him/her. Identify a mutually-acceptable definition of that motivation/satisfaction.

_____

_____

_____

4. Identify at least five alternative activities/pursuits with which your "client" could find at least equal satisfaction of his/her motivation. These five alternatives must be a product of discussion between you and the "client."

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

5. Eliminate temporary alternatives and those activities which the "client" is reluctant to explore. If necessary, return to Question 4 and re-establish potential activities/alternatives which may be acceptable to the "client."

6. Discuss acceptable alternatives with your "client." Identify sources of these alternative pursuits and clarify your "client's" expectations, desires, etc.

ACTIVITY	MOTIVE	CLIENT'S ANTICIPATION OF OUTCOME
_____	_____	_____
_____	_____	_____

ACTIVITY	MOTIVE	CLIENT'S ANTICIPATION OF OUTCOME

7. Negotiate a contract with the "client."

a. Which alternative activity will you select to meet your needs?

b. When will you begin your involvement in this activity?

c. What changes will be realized as a result of your involvement in this activity (obtain commitment)?

d. How will you and I recognize the changes (reinforce commitment)?

e. What will you do for you should that occur (affirmation of commitment to alternative pursuits)?

NOTE: If "client" readily accepts the fact that the alternative discussed will become ineffective (Questions 6d and 6e), you may find it advisable to again return to Question 4 and seek greater resolution/commitment to alternative pursuits.

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STUDY GUIDE AND WORKBOOK

3ALR73430B/30LR7361B/30ZR7364B-III-5-11

Technical Training

Drug and Alcohol Abuse Control

VIABLE ALTERNATIVES

July 1977

Headquarters 3250 Technical Training Wing (ATC)
(USAF Technical Training School)
Lackland Air Force Base, Texas 78236

DESIGNED FOR ATC COURSE USE. DO NOT USE ON THE JOB.

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ATC FORM 214 (LAN 781) OBSOLETES ATC FORMS 214, MAY 69, 522, NOV 69 AND 523, MAY 71. STANDARD COVERSHEET

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Social Actions Training Branch
Lackland Air Force Base, Texas 78236

SW 3ALR73430B/30LR7361B
30ZR7364B - III-5-11
1 July 1977

PURPOSE

This study guide/workbook (SW) is designed to assist you in understanding the viable alternatives concept and its application. The process itself is simple, with the greatest challenge being to the imagination, rather than to the academic ability of the reader. A good listener with an active imagination will be at least as effective as a scholar with all the answers. The specific learning objectives (criterion objectives) associated with each major section of this SW will precede the information.

The viable alternatives concept in this SW is addressed primarily as a preventive or rehabilitative concept applied to drug/alcohol abuse. It is equally effective in other areas of counterproductive or destructive life styles. However, our focus will be in the drug abuse prevention and rehabilitation area.

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SW3ALR73430B/30LR7361B/30ZR7364B-III-5-11

SW B-III-5-11
1 July 1977

OBJECTIVE

Identify the three major objectives of the viable alternatives approach to drug abuse prevention and rehabilitation and eight factors to consider before using this approach.

INTRODUCTION

One of the most important functions in the rehabilitation process is helping your clients establish a viable alternative. It does little good to remove a crutch (drugs/alcohol) without replacing it with something better. Without replacing the crutch, the person will soon go back to using the same or similar crutch because it serves a need in his/her life.

To help identify viable alternatives, you must understand the objectives of the viable alternatives approach, and consider eight factors. By identifying alternatives which meet the needs of your clients, you'll increase the probability of your client remaining off chemicals and leading a more productive and happy life.

INFORMATION

OBJECTIVES OF THE VIABLE ALTERNATIVES APPROACH

Minimize the Adverse Consequences of Drug Use and Prevent Escalation to Stronger or More Dangerous Drugs

One of the major objectives of the viable alternatives approach is to minimize the adverse consequences of drug use and also to prevent escalation to stronger or more dangerous drugs. This objective is in keeping with Air Force policy to prevent drug abuse. Application of the approach in a timely manner to a receptive individual will allow that person to find other activities which provide pleasure or experiences at least equal to the rewards of drug use. Many of us are not prepared to cope adequately with our current environment. Our world is different from that of our parents. In a matter of hours, we are able to travel from one climate to another; from friends to total strangers; and from familiar recreational activities to areas where we can't engage in our favorite activities. Additionally, in a matter of hours, we can go from extreme comfort to extreme stress. Our society has been called a "drug-taking society." In times of stress or discomfort, chemicals

Supersedes SW B-III-5-11, April 1977

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can relieve the symptoms of stress. Consequently, people misuse drugs to forget their problems. Often, with drugs, people seek bigger and better things, and there is someone willing to provide the means to reach that end. Drugs will do the job asked for by the person. A stick of dynamite will kill flies; but, hopefully, there is a better means -- a more viable alternative!

Maximize the Individual's Involvement in Life and Life's Experiences/ Promote the Responsible Use of Chemical Agents

The second of the major objectives is in two parts. With the viable alternatives concept, we hope to maximize the individual's involvement in life and life's experiences. We also hope to promote the responsible use of chemical agents. Very few of us enjoy a totally pleasant life experience. We all have our "ups" and "downs." Some of us are more able to cope with life's disappointments than are others. One means of coping with adverse or unpleasant circumstances is to run from them, or "cop out." Drug abuse is one method of running away from the unpleasant circumstances. We can close our eyes and hope the "bad" situation will disappear. However, that action is generally not enough. The viable alternatives process encourages the individual to live life to its fullest, enduring stresses and strains, and continuing in a productive direction toward accomplishment of personal goals. The other consideration of this twofold objective is the responsible use of chemical agents. We enjoy a technology which has provided medication to ease discomforts of illness and pain. Used wisely and responsibly, medication can prolong our productive lives, and help us through times of discomfort. Self-medication is seldom wise. The medicine which was prescribed for our chest cold last year may no longer have the properties to cure it this year. Responsible use of chemicals is that use when and which is directed by a doctor.

Produce a New State of Consciousness

The final consideration or objective of the viable alternatives approach is to produce a new state of consciousness for the user or non-user and improve their individual sense of worth. We hear today of "dehumanization, of being a cog in the wheel," rather than an important part of the system. Many of us have occasions when we feel insignificant and insecure. From our feelings of insignificance and insecurity grows self-doubt. Forms of insecurity affect people in different ways. Financial insecurity has led people to work excessively and not allow for rest and recreation, ending up in ulcers and other forms of illness. Social insecurity can cause us to try to "keep up with the Joneses," with two cars we can't afford, etc. Peer pressure invites the individual to adapt to the group norm, or to perform as the group would wish. The insecure individual is especially susceptible to such pressure. The viable alternatives concept allows for individual choices and support in carrying out these choices and enjoying the results of the activity or attitude. In applying the concept, we will be assisting people to find their own potency in attaining the goals they have set for themselves.

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EIGHT FACTORS TO CONSIDER BEFORE USING THE VIABLE ALTERNATIVES APPROACH

Individual Needs (Maslow's Hierarchy of Needs)

The first of the factors is the individual's needs. Maslow's hierarchy of needs provides a simple model of which to base our exploration of individual life styles to determine which "needs" areas are deficient. Maslow identifies the basic survival needs as common to all people. We all require food, shelter, oxygen, etc., for our bodies to exist. Generally speaking, these needs are met for all of us, or we would not exist at all.

SECURITY NEEDS. The next level of needs identified by Maslow are the security needs. In this area, we can categorize financial security, personal safety, etc.

BELONGING. The third level in the hierarchy is belonging. Man is basically a social animal. We require friends and associates and, therefore, we join clubs, form circles of friends and associates, and identify with our families.

ESTEEM. Following belonging in the needs hierarchy is a need for esteem, both self-esteem and esteem for others. We need to accept others as well as ourselves.

SELF-ACTUALIZATION. The top of the hierarchy, according to Maslow, is self-actualization. At this point, the individual recognizes personal assets, as well as limitations, and is self-motivated to reach his/her full potential. Maslow's theory is based on progression from fulfillment of the basic survival needs through self-actualization. It is improbable that an individual would be deficient in one area and still be able to progress beyond that area to the next level in the needs hierarchy. The viable alternatives concept applies to the fulfillment of individual needs, allowing the individual to grow and meet full potential.

Value System/Orientation

Next, we must consider the individual's value system. This system may or may not correspond to the value system of the counselor. However, the client is the individual being served.

Level of Satisfaction Derived from the Abused Substance

The third consideration is that the level of satisfaction derived from the abused substance will affect a decision about an alternative. The individual who is convinced that experience with drugs is the most satisfying experience possible will be difficult to help. On the contrary, an individual who is displeased with the drug experience is generally quite eager to accept alternative means of satisfaction. In a different sense,

"Hamburger Helper" would probably be more attractive to an impoverished family than it would be to those affluent members of our society who are familiar with exotic meals.

The Level of Experience with the Drug Substance Will Affect the Alternative Selected

Closely related to the previous factor is the fourth consideration: the level of experience with the drug substance(s) will affect the alternative selected. Individuals are motivated to continue drug use and perhaps escalate to more potent substances by their experiences with various substances. The addict has a different motive for drug use than does the experimenter. As people's experience with drugs continues, they become more aware of the means of using the substances and effects, and may move to more potent chemicals. The satisfaction derived from a viable alternative must at least equal the satisfaction from the use of chemical substances. Preferably, the alternative should be more satisfying.

The Type of Drug Abused is Often a Key to the Motivation of the Abuser

When interviewing a client to apply the viable alternatives concept, it is important to determine the type of drug abused by the client. This is the fifth factor. The type of drug: i.e., hallucinogen, stimulant, depressant, etc., is often a key to the motivation of the abuser. Depressants are often used to withdraw from an unpleasant reality, while hallucinogens and stimulants are often used to intensify sensations received from the individual's environment. If clients are seeking excitement through drugs, they will probably be receptive to an exhilirating alternative, such as motorcycling, mountain climbing, etc. On the contrary, if the drug substance is used to achieve relaxation, the outcome of the alternative should be relaxation.

Lack of Awareness by Commanders/Supervisors Can Act As a Barrier to Alternatives

The sixth factor concerns our supporting organization. Since we are not independent of a supporting organization and society (the Air Force), we must also consider the reaction of that supporting system to our proposed alternatives to chemical abuse. It is important that we realize that a lack of awareness by commanders and supervisors can act as a barrier to alternatives. Specialists do not welcome change. Commanders and supervisors have specialized in a life style which is compatible with their personal experience in the military society. Alternative proposals are often non-traditional and may seem to attack the life style which commanders believe is most appropriate for military members or dependents. Commanders' or supervisors' intentions can be very honorable, but they may not understand the features of our proposals, and may fail to see the value of the alternative proposal.

Alternatives Must Be Viable to the Drug/Alcohol Abuser

The seventh factor is an extremely important consideration. The alternative must be viable to the drug/alcohol abuser. Viable means a workable and sustainable condition. The individual must have the means and the interest to enjoy the alternative. Yachting is an enjoyable activity and would be an ideal alternative for many of us. However, the majority of us do not have the financial resources and, perhaps, not even the time to engage in this activity. Remember, the viable alternative is a highly individualized concept. For this reason, hobby lists are not satisfactory as viable alternatives.

Alternatives Should Not Be Temporary In Nature

Finally, alternatives should not be temporary in nature. A temporary alternative offers, at best, temporary satisfaction, and encourages recidivism (repeated or habitual relapse). There must be an opportunity for commitment to the alternative activity, so it becomes an important part of the individual's life style and continually provides satisfaction for that individual. If the person's only alternative is outdoor swimming and he/she lives in North Dakota, chances are that he/she will have trouble maintaining interest in that alternative after the summer months have passed.

Exercise 5a

Complete the following exercise.

What are the three major objectives of the viable alternatives approach?

1.

2.

3.

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What are the five levels of Maslow's hierarchy of needs?

1.

2.

3.

4.

5.

FACTORS AFFECTING ACCEPTANCE OF ALTERNATIVES

OBJECTIVE

Identify major factors which affect client acceptance of alternatives.

INTRODUCTION

In proposing alternative means of satisfaction for individuals who have found pleasure and satisfaction in substance abuse, it is important that we understand certain factors which will probably affect their acceptance of the alternatives. This may require that we accept certain, perhaps, unpleasant realities.

THE USE OF MOOD-ALTERING SUBSTANCES IS USUALLY PLEASURABLE

No matter what our personal views may be about the effects and consequences of mood-altering substances, the user probably finds their use to be pleasurable and satisfying. Very few of us would ever intentionally do something to ourselves which is going to be unpleasant and cause dissatisfaction. Some eat spinach because they like it or believe it to be healthy, while others would not touch spinach for equally valid reasons. The decision to use drugs is individual, as is the perception of the pleasure and satisfaction derived from drug use.

PEOPLE START AND MAY CONTINUE USE (ABUSE) OF DRUGS BECAUSE THEY WANT TO DO SO

This factor is closely related and very similar to the preceding point, but it remains an important issue. Probably, the individual's first use of drugs was not forced upon him/her. Peer pressure may have been involved, but the fact remains that the initial decision and act were voluntary, with available options. After the first use of drugs, the individual probably found some degree of pleasure or gratification of needs through the drug substance, or perhaps through the association with others who were using drugs concurrently. The individual again has the option of returning to drug use and the resultant associations, or perhaps escalating the drug use to a more potent substance, or of quitting. It is not the drug substance itself which caused the use. There is no intrinsic nature of any drug substance which can force an individual to begin and continue substance use or abuse. Even the most severely affected addict, under the proper conditions, can abstain from drug use. Abstinence may be uncomfortable, and without proper care, it may be extremely dangerous, but not impossible.

DRUGS DO NOT COMPEL BEHAVIOR

Drugs and alcohol affect our central nervous system (CNS) and alter our consciousness, but they do not compel us to act in any certain way. There is no substance available which can be administered to cause a person to come to a position of attention, march 100 yards at quick time, halt, left face, or open ranks. We do, however, have many substances available which will cause us to lose our inhibitions, and not feel restrained from doing things which we would not normally do. We can alter our perception of our surroundings by taking drugs, and we can hallucinate, or induce a state of sleep; but, we have still failed to compel behavior. We can cause our system to be more or less sensitive to outside stimuli, such as pain, light, movement, etc., but we have only succeeded in altering our perception, not compelling our behavior.

PSYCHOLOGICAL DEPENDENCE RESULTS WHEN THE DRUG EFFECT FILLS A NEED

Most of us have become psychologically dependent on certain activities and substances, and not all of us are chemical abusers or criminals. One form of dependence is on ritualistic happenings. When we return to our families after a day at work, we expect to be greeted in a certain way. If we are not greeted in that certain way, we may become upset and uncomfortable because our expectations have not been met. Breakfast before leaving for work or the first cup of coffee in the morning are other illustrations of how easily we can become psychologically dependent. We often avoid talking to certain of our associates until after they have had their first cup of coffee in the morning. Psychological dependence is not an exotic disease reserved for deviant persons.

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STEREOTYPES OF DRUG ABUSERS ARE INACCURATE

Drug abusers are not necessarily immature, immoral, irresponsible, or socially-disadvantaged. This misconception has been with us for a long time, and is nearly as accurate as the idea of storks bringing babies. At one time, this myth may have been a way for society to care for its collective conscience. But, today, we are aware that drug use crosses all cultures and all socio-economic classes. There is no such thing as immunity because of one's particular station in life. The drug user has taken a turn in life which is not socially acceptable in terms of that portion of society which legislates on behavior and morality. We all have our ways of escaping the stresses of our reality. The difference lies in which of these methods is considered <u>acceptable</u> by the majority of our society.

ALL USE OF ILLEGAL OR SOCIALLY DISAPPROVED DRUGS IS <u>NOT</u> NECESSARILY ABUSE OR ADDICTION

This factor is somewhat controversial; however, it is important to understand that the legality issue is not addressed. If we consider abusive to mean physically damaging, then there are certain types of substances and certain methods of administration which are not abusive. Certainly, we realize, at this point, that not all substances are capable of creating the condition known as addiction. Many of the substances which are socially disapproved under certain conditions are totally approved when medically prescribed. Stimulant and depressant substances are often prescribed by competent medical authority, and then used beyond what is medically required, but remaining within the realm of the prescribed dosage. The same substance in the possession of an apprehended youth without a prescription is sufficient to bring about imprisonment/criminal charges. Many of the illicit substances we are concerned about are very beneficial when properly applied. Much use occurs as a result of experimentation under medical supervision.

DRUGS CHANGE CONSCIOUSNESS

The important factor in many forms of pleasure-seeking (gratification) behavior is the resultant change in the mood or consciousness of the person. In most instances of drug use, the administration of the substance is not the end-result. The substance is administered in order that the individual may enjoy changed feelings (altered perceptions/consciousness) which come about as the drug takes effect. It is probably not necessary to find an alternate activity to take the place of the administration of the substance; however, it is probable that we must seek an alternative which will provide at least an equal gratification of individual needs (pleasure).

EXPERIENCE IS A PREREQUISITE FOR MATURITY

At one time or another, we have all been told that we would believe differently after we have had the experience of "growing up," or going through some experience which affected the thoughts of someone else. "If you had only seen this. . . ," or, "If you had only been there. . . . are ways of saying, "With experience, you would somehow be different than you now are." Drugs offer instant experience and awareness and thus hold an attraction. Unfortunately, the types of experience and awareness afforded by drugs is not an acceptable form of learning. There are many acceptable ways of gaining experience, and it is extremely unfortunate that many members of our society have not been exposed to the wide variety of experiences available. Ignorance is tragic, because the individual might not know any way to exist other than the way to which he/she has been exposed. Natural creativity is a great resource which often goes untapped, because the individual has not been exposed to a wider environment and allowed to exercise productive skills. In these untapped resources can be found many viable alternatives.

PEOPLE STOP USING MOOD-ALTERING SUBSTANCES ONLY AFTER THEY DISCOVER SOMETHING BETTER

Individuals do not stop using mood-altering substances (or pleasure-seeking behavior) until they discover something better. Think of a pleasant activity in which you engage and which you enjoy very much. Now, try to imagine someone taking that activity from you and not replacing it with anything. If you need some help in this area, consider some of the simple things in life, such as cigarettes, coffee, a favorite food, reading materials, etc. The alternative must at least equal the pleasure or satisfaction found in the undesirable behavior.

ALTERNATIVES REDUCE OTHER SELF DESTRUCTIVE BEHAVIOR

Alternatives to drug abuse are also alternatives to the distresses and discomfort which lead to any self-destructive behavior. Self-destructive behavior is not necessarily as drastic as suicide. Worry, overwork, etc., can be destructive in terms of the effect on the body. Doctors often speak of the "will to live," which plays an important role in the case of seriously ill or injured patients. We all need to take good care of ourselves, and viable alternatives exist for nearly any unpleasant or unproductive situation. Meditation is a way of coping with stress and strain. "Day dreaming" also helps us escape from reality, if only for a moment. We are all capable of saying, "I have worked enough for now, and I will take a break to relax." Often, we find that a short break brings about increased productivity when we return. A viable alternative is just another way of taking care of

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oneself. It is also possible that if your base has a workable alternative pursuits program it is possible that other base problems like AWOL, Article 15s, EOT complaints, morale-related problems, etc., may be reduced.

Exercise 5b

Complete the following exercise.

What are the ten major factors which affect client acceptance of alternatives?

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

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SELECTION CRITERIA FOR AN ALTERNATIVE PURSUIT

OBJECTIVE

Identify five selection criteria for an alternative pursuit.

INTRODUCTION

When we select an alternative to drug or alcohol abuse, we must insure that the alternative is individually designed and satisfies the motivation by each person for which that alternative is being proposed. We must also pay careful attention to the other areas considered in this objective for failure to consider any of them could result in an ineffective alternative.

INFORMATION

MUST BE ACCEPTABLE TO THE CLIENT

Any alternative pursuit (viable alternative) we elect must be acceptable to the client. It is an alternative for him/her and not for the counselor. A counselor may like to fish and hunt; but, his/her client may be a conservationist, very much opposed to fishing or hunting. In that case, wildlife photography may be more acceptable to the client. Clients must be able to engage in alternatives and derive satisfaction from them.

MUST BE ACCEPTABLE TO THE GOVERNING SOCIETY/INSTITUTION

Our clients come to us because they need to replace an unacceptable activity. Generally, that unacceptable activity is unacceptable to both the individual and the governing society/institution. It may only be unacceptable to the individual because of the consequences of continued activity; but, it is, nevertheless, unacceptable. That same society/institution which found the original activity unacceptable reserves the right to disapprove of other activities. We are all aware of the objectives of the Air Force and the types of activities which support those objectives. For this reason, our proposed alternatives will probably be more acceptable to the institution if they are advanced with the needs of the Air Force in mind.

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MUST BE AN ATTAINABLE OBJECTIVE

Alternatives must have attainable objectives in terms of cost, time, and legality/acceptability. These three factors are extremely important. With the alternatives concept, we are often speaking of change and a new investment of time and effort, as well as money. Will the investment be worthwhile to the institution or individual making the investment?

MUST OFFER AN OPPORTUNITY FOR INDIVIDUAL COMMITMENT

An alternative proposal is only a proposal, unless the individual becomes committed to acting on the alternative. Unless that commitment endures, the alternative is no longer acceptable as "a workable and sustainable condition." The behavior we are replacing with a viable alternative was apparently a committed behavior, since the individual persisted in his/her efforts. If we fail to replace that commitment with an acceptable commitment, we have then failed to provide a true viable alternative.

MUST BE ABLE TO PRODUCE CHANGE

Alternatives must be capable of producing discernable changes toward self and others and experiences of clients. Clients who have used chemicals, or are otherwise bringing stress and strain upon themselves, are avoiding or altering some part of reality to a point where existence is at least tolerable. These individuals are likely to have some difficulty in certain surroundings, and, thus, have altered their surroundings, their associates, or their personal perception. Alternatives must be capable of producing change in the way people feel about themselves and others, as well as assist in enriching their life experiences. Many of us have experienced a full and exciting life, and fail to recall the challenge of some of our fundamental efforts. Childhood hikes (for the experienced mountain climber) may no longer be fascinating or exciting, but they may be for the inexperienced hiker. Through new experiences, clients have an opportunity to expand their available activities and experiences, and also have other activities with which to structure time, temporarily escaping the pressures which may have been intolerable without a place to escape. Through relaxation and accomplishment, clients are likely to feel differently about themselves and others, and lead more productive and rewarding lives. For many people, the realization that "pursuit of happiness" is not necessarily the same as the accumulation of material objects and monetary wealth is sufficient to allow them to relax and enjoy life. That one realization, if it applies, fits the criteria affixed to a viable alternative.

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Exercise 5c

Complete the following exercise.

What are the five selection criteria for an alternative pursuit?

1.

2.

3.

4.

5.

ACCEPTANCE BY APPROVING AUTHORITY

OBJECTIVE

Identify three features that alternative pursuits should possess in order to gain maximum appeal to approving authorities.

INTRODUCTION

If we are to get approving authorities to accept our alternative proposals, we must insure that they are: cost effective, complement the desires of the approving authority and contain provisions for evaluation so that their worth can be documented.

INFORMATION

ALTERNATIVES PURSUITS SHOULD BE COST-EFFECTIVE AND SOUND

Alternative pursuits should be cost-effective and based on sound principles. Before proposing alternative pursuits or viable alternatives, we must consider the needs of the organization we are serving. That organization has appointed a hierarchy of managers to act in its behalf. Approval undoubtedly will be required from one of those managers before a proposal can be implemented. All effective managers are concerned with cost-effectiveness and outcomes. Cost-effectiveness is nothing more than

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getting the most for monetary investment. To the institution, time may be considered money, since it is responsible to pay for the services of those who provide the time. The institution may compare your proposal with several other proposals, or perhaps traditional approaches to the situation, and evaluate the cost-effectiveness of all available options before making a decision.

Basing a proposal on sound principles, rather than wild speculation, will also go far in gaining the concurrence of the approving authority. Our ideas will not be without precedent somewhere else in the world. Thus, we have the opportunity to evaluate the conditions which existed somewhere else, where the alternative either was or was not successful. Compare these conditions to those in your situation, and then make your case or abandon the original idea. As an example, water skiing may provide a client with excitement and physical exercise and be a fantastic alternative pursuit in Texas; however, that same activity may not be appropriate as a viable alternative (workable and sustainable condition) in Alaska. In researching proposals, one should be able to make several statements of principle; i.e., this will work because of these conditions, etc. There should be an approximate time table of events, if the alternative pursuit proceeds as the counselor and client have planned. Obstacles will be identified before they are encountered and preparations made to overcome them; or, it may be determined that the obstacles are too great and the plan should be abandoned for a more effective one.

COMPLEMENT DESIRES OF APPROVING AUTHORITY

Alternative pursuits which are adopted should complement the desires of the approving authority. In social actions, it is important that we understand and support the objectives of the approving authority. The service we provide the system is to reorient individuals who have somewhere strayed from the accepted standards of behavior, as determined by the same authority who approves or disapproves our proposed alternatives. We serve the individuals in much the same way. Those who wish to remain in the Air Force are assisted in their transition from unacceptable behavior to acceptable behavior. Those who do not wish to change their behavior have also determined that they do not wish to meet Air Force standards of behavior and conduct, and reject the opportunity to remain in the Air Force. The approving authority (the Air Force) wishes to retain quality personnel and advance mission effectiveness. The Air Force wishes to provide for the health and welfare of its personnel within the limitations of the budget, and is naturally interested in doing more with less. It is relatively easy to fit an alternative proposal within the desires of the approving authority, if we have done our homework and are prepared to explain the principles supporting our proposal and establish the cost-effectiveness of the alternative and its outcome.

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ALTERNATIVE PURSUITS PROPOSALS SHOULD INCLUDE PROVISIONS FOR EVALUATION

Alternative pursuit proposals should include provisions for evaluation in order to measure and report their effectiveness. One of the questions which will undoubtedly cross the mind of the approving authority is, "How will we know if this idea is working as we want it to?" The question is valid, not only for the approving authority, but also for the individual proposing the alternative. As you have done your research for precedents, cost-effectiveness, etc., you have obviously seen data which will serve effectively as milestones as your alternative pursuit progresses. You should be able to predict reasonably accurate points in time where certain events will occur, such as changes in the individual's performance, attitude, etc. Remember, the only basis for proposing the alternative is to bring about some sort of change. If you have tailored your alternative proposal to your client, you will be able to define the changes you expect to occur; i.e., more productivity, better appearance, etc. Additionally, you will be able to identify checkpoints/suspenses for these changes to be evaluated. The approving authority is interested in knowing of your success and/or lack of it. This factor is closely related to cost effectiveness and the desires or objectives of the institution. You should also be interested in whether or not predictable objectives/goals are being met as planned. If your proposal is not effective (workable and sustainable), it is probable that the ineffectiveness will appear during an interim evaluation. This provides an opportunity to correct and redirect your efforts or abandon the plan before you invest the time, effort, and resources of yourself, your client, and the approving institution any further.

Exercise 5d

Complete the following exercise.

What are the three features which alternative pursuits should possess in order to gain maximum appeal of approving authorities?

1.

2.

3.

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ANSWERS TO EXERCISES

Exercise 5a

1. Minimize adverse consequences of use and escalation to stronger or more dangerous drugs.

2. Maximize involvement in life experience(s) and promote the responsible use of chemical agents.

3. Produce a new state of consciousness for the user or non-user and improve his/her sense of worth.

1. Self-actualization

2. Esteem

3. Belonging

4. Security

5. Survival

Exercise 5b

1. The use of mood-altering substances is usually pleasurable.

2. Why people use drugs.

3. Drugs do not compel behavior.

4. Psychological dependence.

5. Stereotypes are inaccurate.

6. Not all use is addictive.

7. Drugs change consciousness

8. Experience is a prerequisite to maturity.

9. Stopping for something better.

10. Alternatives reduce other stressors.

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Exercise 5c

1. Must be acceptable to the client.
2. Must be acceptable to the governing society/institution.
3. Must be attainable.
4. Must offer an opportunity for commitment.
5. Must be able to produce change.

Exercise 5d

1. Cost-effective and sound.
2. Complement desires of approving authority.
3. Effectiveness evaluation.

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Social Actions Training Branch
Lackland Air Force Base, Texas

LP BB-III-1.7 (1)
1 August 1978

STUDENT NAME_____ RANK_____ DATE_____

INSTRUCTOR_____ GROUP_____

VIABLE ALTERNATIVES WORKSHEET

OBJECTIVE: Given a diad role-playing situation and the Viable Alternatives Interview Worksheet, satisfactorily guide the client through the Viable Alternative process using the worksheet in accordance with the grading criteria.

In small groups, each student will select a partner. Each student will complete a Viable Alternatives Interview Worksheet which must be discussed. Students are free to expand each area spontaneously to obtain an in-depth understanding of current activities, the dominant value structure and motivations leading to the activities in order to propose, discuss, and reach consensus on alternative pursuits for the client.

Worksheet	Circle One
1. Using the values clarification concept of (a) prize, (b) choice, and (c) affirm, identify at least three valued activities/interests of your "client."	S NI U
a. _____	Correct/Incorrect
b. _____	C I
c. _____	C I

NOTE: This area will clarify the PRIZE portion of the values clarification process and is an integral part of the viable alternatives process.

2. Identify and reach agreement on the motivations/satisfactions attached to each of the foregoing activities.		S NI U
ACTIVITY	MOTIVATION/SATISFACTION	
a.	_____	C I
	_____	C I
b.	_____	C I

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ACTIVITY	MOTIVATION/SATISFACTION		
c.	_____	C	I
	_____		

3. Discuss and eliminate lesser motivations/satisfactions until the "client" selects ONE motive or satisfaction which is of primary importance to him/her. Identify a mutually-acceptable definition of that motivation/satisfaction. S NI U

_____

_____

_____

4. Identify at least five alternative activities/pursuits with which your "client" could find at least equal satisfaction of his/her motivation. These five alterntives must be a product of discussion between you and the "client." S NI U

(1) _____ C I

(2) _____ C I

(3) _____ C I

(4) _____ C I

(5) _____ C I

5. Eliminate temporary alternatives and those activities which the "client" is reluctant to explore. If necessary, return to Question 4 and re-establish potential activities/alternatives which may be acceptable to the "client." S NI U

6. Discuss acceptable alternatives with your "client." Identify sources of these alternative pursuits and clarify your "client's" expectations, desires, etc. S NI U

ACTIVITY	MOTIVE	CLIENT'S ANTICIPATION OF OUTCOME	
_____	_____	_____	C I
_____	_____	_____	C I

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ACTIVITY	MOTIVE	CLIENT'S ANTICIPATION OF OUTCOME		
_____	_____	_____	C	I
_____	_____	_____	C	I

7. Negotiate a contract with the "client." S NI U

a. Which alternative activity will you select to meet your needs?

_____ C I

b. When will you begin your involvement in this activity?

_____ C I

c. What changes will be realized as a result of your involvement in this activity (obtain commitment)?

_____ C I

_____

_____

d. How will you and I recognize the changes (reinforce commitment)?

_____ C I

_____

_____

e. What will you do for you should that change occur (affirmation of commitment or alternative pursuits)?

_____ C I

_____

_____

NOTE: If "client" readily accepts the fact that the alternative discussed will become ineffective (Questions 6d and 6e), you may find it advisable to again return to Question 4 and seek greater resolution/commitment to alternative pursuits.

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SCORING INSTRUCTIONS: The worksheet is divided into seven major areas and several sub areas. All sub areas must be correct to receive a satisfactory for the seven major areas. To receive a needs improvement, no more than one-third (1/3) of the sub areas may be incorrect. To receive an overall satisfactory, you must have at least six of the major areas satisfactory and no unsatisfactories. You must have a minimum of six overall satisfactories to complete the practicum.

OVERALL GRADE_____

STUDENT ACKNOWLEDGEMENT DATE

LEDGEND

S - Satisfactory
NI- Needs Improvement
U - Unsatisfactory
C - Correct
I - Incorrect

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SOCIAL ACTIONS TRAINING BRANCH
Lackland Air Force Base, Texas

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LP BB-III-1.9 (1)
1 August 1978

COUNSELING TECHNIQUES PRACTICUM PERFORMANCE TEST

STUDENT NAME _____ RANK _____ DATE _____

INSTRUCTOR _____ GROUP ___

☐ Practice ☐ Evaluation ☐ Remake ☐ ROLE PERPRON

COUNSELOR BEHAVIOR	S	MI	U	MO	INSTRUCTOR'S REMARKS
1. PHYSICAL SETTING					
a. Determines suitable seating arrangement and no physical barriers.					
b. Body Posture					
c. Eye Contact					
d. States time limit					
e. Appears comfortable and relaxed					
2. COUNSELING RELATIONSHIP					
a. Actively listens to client's verbal and nonverbal communication					
b. Is non-judgemental					
c. Accepts client					
d. "RESPECTS" client					
e. "RISKS" effective confrontation of client's verbal and nonverbal communication which indicates incongruence/ contradictions					
3. COUNSELING TECHNIQUES					
a. Uses Reflective Questioning Techniques					
b. Uses "here and now" information					

RAPPORT

DESIGNED FOR ATC COURSE USE DO NOT USE ON THE JOB

Attachment 1

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COUNSELOR BEHAVIOR	S	NI	U	NO	INSTRUCTOR'S REMARKS
3. COUNSELING TECHNIQUES (Con't)					
c. Opens only relevant issues capable of dealing with during time of session					
d. Does not interrupt client inappropriately					
e. Summarizes client's information					
f. Does not use psychiatric labels, unfamiliar terms					
4. PROCEDURE					
a. Define central issue(s) to the client's understanding					
b. Follows logical sequence, and is understood by client					
c. Information given is accurate					
5. CLOSURE					
a. Offers appropriate referral when necessary					
b. Establishes contract ("Homework" and future session)					
c. Notifies client of closure appropriately					
d. Elicits client's summary of session					

SCORING INSTRUCTIONS: A "Satisfactory" will be given if there are no "Unsatisfactories" and no more than eight (8) "Needs Improvements".

OVERALL RATING S U

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Student Acknowledgement

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Social Actions Training Branch
Lackland Air Force Base, Texas

HO 3ALR73430B/
30LR7361B/30ZR7364B-III-1-1
16 June 1978

COUNSELING TECHNIQUES
PART IX - PERSONNEL PROCESSING SQUADRON DISCHARGEE PRACTICUM

OBJECTIVE

Placed in an actual counseling environment, establish a satisfactory counselor/client relationship and effectively use crisis intervention techniques in accordance with the criteria listed in the Dischargee Counseling Practicum Performance Test.

INTRODUCTION

Each student will be provided an opportunity to participate in the counseling practicum. The following information will provide you with the instructions you'll need to accomplish this objective.

INFORMATION

COUNSELING INSTRUCTIONS

1. During Block IV each student will participate in two evening counseling sessions with personnel from the 3731 Personnel Processing Squadron (PerPron).

2. The PerPron personnel you will be counseling are usually being separated from the Air Force for one of the following reasons: drug abuse, homosexuality, or medical. This is a critical and often traumatic time for these people. Most of the PerPron personnel have been at Lackland from three to seven days which in most instances has not been a pleasant experience.

3. Your group will meet on both evenings at 1800 Hrs in Room 106 (Bldg. 10634). The group facilitator will insure the building is open. After the PerPron personnel arrive on the first evening, the group facilitator will spend a few minutes explaining what Social Actions is about and the purpose of the counseling sessions. A predesignated group leader will then take charge of the group and conduct an introductory "ice breaking" exercise. This exercise will be developed by the group during a group facilitation hour prior to the practicum. The "ice breaker" is designed to promote a relaxed, non-threatening atmosphere and incorporate a method for assigning a counselor to each person from PerPron. Your facilitator

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will be more specific on how to develop an "ice breaker".

4. Each counselor will be assigned a specific room where the counseling will be performed. You will be evaluated both evenings by an assigned facilitator who will periodically observe your counseling session. The first evening will be a practice session and the second evening will be a graded evaluation. The Counseling Practicum Progress Checklist is the evaluation form that will be used.

5. After each counseling session has terminated the PerPron personnel will fill out, anonymously, a critique (ATC Form 736) expressing their impressions of the evening. They will then be released and returned by bus to the PerPron area.

6. The evening will conclude with the group processing each counseling session and receiving feedback from the facilitator. This will take place in Room 106.

7. This is an excellent opportunity for you to help someone in need and to put into use the counseling skills you have developed.

PRACTICUM SCHEDULE (FIRST EVENING)

1800 - Participating group and facilitator assemble in Room 106 (Social Actions, Bldg. 10634).

1815 - Social Actions briefing and introductory exercise ("ice breaker") conducted. Counseling rooms assigned.

1830 - Counseling sessions commence.

1945 - Counseling sessions terminate.

1950 - PerPron personnel fill out counseling critiques.

2000 - PerPron personnel depart for the 3731st area.

2000 - Evaluators conduct critique and feedback to students.

2100 - Group closure.

SECOND EVENING

1800 - All group members and PerPron personnel assemble in Room 106 for any additional instructions that may be given for this session.

1810 - 1815 - Counselors and PerPron personnel will proceed to the

rooms they used the previous evening. Counseling will begin.

1945 - Counseling sessions terminate.

1950 - PerPron personnel fill out counseling critiques.

2000 - PerPron personnel depart for the 3731st area.

2000 - Evaluators conduct critique and feedback to students.

2100 - Group closure.

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PLAN OF INSTRUCTION/LESSON PLAN PART I

NAME OF INSTRUCTOR	COURSE TITLE
	Drug and Alcohol Abuse Control

BLOCK NUMBER	BLOCK TITLE
III	Counseling Techniques

1 COURSE CONTENT

2. Crisis Intervention/Telephone Counseling

CRISIS INTERVENTION/TELEPHONE COUNSELING (TECHNIQUES)

a. Identify crisis intervention techniques associated with drug/alcohol clients.

b. Identify crisis intervention and telephone counseling techniques associated with client and/or caller problems.

CRISIS INTERVENTION/TELEPHONE COUNSELING (PRACTICUM)

c. Given a role-played crisis situation and telephone trainers, satisfactorily identify client problems, use satisfactory telephone counseling technique, and offer an appropriate referral in accordance with the criteria listed on the Crisis Intervention/Telephone Counseling Performance Test.

SUPERVISOR APPROVAL OF LESSON PLAN (PART II)

SIGNATURE AND DATE	SIGNATURE AND DATE

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SUPPORT MATERIALS AND GUIDANCE

Student Instructional Materials
SW B-III-2-3, Crisis Intervention/Telephone Counseling
WS B-III-2-6, Crisis Intervention/Telephone Counseling Role Sheet
PT B-III-2-9, Crisis Intervention/Telephone Counseling Performance Test

Audio-Visual Aids
35mm Slides, Crisis Intervention/Telephone Counseling
16mm Film, "What Did You Take?" (FLC 23-0092, 35 min)

Training Equipment
Telephone Trainers (10)

Training Methods
Lecture (6.5)
Discussion/Performance/Group (8.5)

Multiple Instructor Requirements
Other (2)

Instructional Guidance
Introduce the concept of crisis intervention and stress telephone counseling as an application of this model. Emphasize Air Force requirements for a telephone counseling service and recommended counselor qualifications and training. Discuss the various types of encounters that might be experienced by counselors and the techniques for handling these situations. Integrate student role-playing of various situations in support of criterion objectives, on a time-permitting basis. Provide telephone trainers to add realism and use in all evaluations - have students reverse roles as counselors and clients - evaluate performance.

MIR: Two instructors are required throughout this lecture to clarify techniques and skills taught through demonstration. Between 12 and 24 separate demonstrations are normally given.

3. Review, Measurement and Critique 3

REVIEW, MEASUREMENT AND CRITIQUE (3.1)

a. Review (1)
b. Measurement (1)
c. Critique (1)

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CRISIS INTERVENTION/TELEPHONE COUNSELING ROLE

INSTRUCTIONS

Each of you will be given the opportunity to use the telephone trainer while in this 6 hours of group time. An ideal way that has proven satisfactory is to have someone volunteer to be the first caller, and as the phone rings, someone in the group volunteers to be the counselor. The role player caller will be able to either use one of the scripts attached to this handout, or can develop a script of his/her own.

The emphasis of both the caller and the counselor is realism. Make the call as real as possible, and make the counseling as real as possible. Use of imagination is definitely encouraged.

As the counselor is talking over the phone, the other group members should be making notes in order to critique the counselor's actions. In addition, the caller will be asked to comment on feelings about being "counseled" by that person.

The facilitator will evaluate, using the evaluator's checklist, Attachment 1. A counselor will be graded satisfactory if he/she does not receive any unsatisfactory or more than (5) needs improvement.

After playing your role as counselor, you should assume the role of the caller.

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ROLE 1 What kind of goddam town do you have here? Jesus, everywhere I go, if it's not a bunch of faggots and queers swishing around, it's the coons and spics reuniting. What the hell kind of place is this anyway---and I expect a decent answer.

ROLE 2 I would like your opinion given this choice. I purchased a tab of acid from a friend of mine. He said it was very mild, a good one for those who have never tripped before. I have always wanted to try LSD once - I have heard all about the controversies and so I believe I know what I'm getting into. However, I would still like to hear what some other people have to say about it. I've made the transition to a freak almost, the acid is the last stage--so can you tell me what acid is all about?

ROLE 3 I have a problem. It's about this guy. You see, I am gay and I'm having a love quarrel. John, that's the name of my lover, is more straight than gay. He has recently met this girl who is more exciting than me - so he says anyway. If he continues seeing this girl, it will only mean heartbreak for me. I've never thought about suicide before now, but everyday just brings more and more confusion. People say I'm strange, and maybe everybody would be just as happy if I just happen to disappear.

ROLE 4 (sobbing) I've got a terrible problem and I need some answers pretty quick. If your fiance was away, like going to another school and you got pregnant by what you thought was a good friend, how would you tell your fiance the situation? I mean, I'm getting an abortion, so that's all taken care of, he doesn't even need know about it, or anything like that, but I feel I've got a responsibility to tell him about the situation. I think he deserves to know about what went on and what a rat I am, but I don't know how to tell him. I just don't know.

ROLE 5 Your ad said that you were interested in other people's problems. so I'm gonna lay a heavy one on you. I've been dating this black chick for about three months now. There wouldn't be a problem except that I'm white. I've been raised to see no difference between white and black and I believe that I exhibit this point of view myself now as an adult. The problem is with my chick who somehow believes that I should see a difference between us - she is always testing me to see if I have yet become a racial bigot. I am getting tired of this but I feel something special for this chick. As though matters weren't bad enough, she is now pregnant; I believe it is probably my kid, but there always exist the chance that it could be one of her black brother's. So here is the problem: Now, what is the answer?

ROLE 6 I'm so happy I just don't know what to do. I went out with this guy that I've had my eye on since high school. It was so neat! He acts absolutely in love with me. He didn't say anything about calling again, but I'm sure he will.

ROLE 7 I am flunking a class and I can't afford to flunk it. The instructor is really understanding, but I just can't grasp the material. He spends all kinds of time with me, but it doesn't seem to do any good. I need the credits now in order to graduate. I can't get them later because I'm taking maximum loads all the way until graduation. I've considered really going all out and cheating to get through the class, but I can't really justify it. I've got to have the credits, one way or another, but I don't know what to do. What would you do in my case?

ROLE 8 Yeah, um ... I have this problem, and I don't know what anybody's going to do about it, because it's not the sort of thing that has an answer, but --- oh, a couple of months ago, I met this guy at the VIP and I don't know, we sort of hit it off and so I ended up going over to his apartment ---and---oh, we drank a little over there, and smoked a little, and I ended up getting really, really drunk and really stoned, and I ended up going to bed with him ---and---well that was okay. I didn't even hear from him after that, and that didn't really bother me, because, well, you know, I was kind of embarrassed about it ---I mean, I don't usually do things like that, but--- I walked into my discussion group for one of my upper division classes this quarter, and lo and behold, he's a grad student and he's teaching the discussion group. I just about died of embarrassment when I walked in, but-- I mean, there's nothing I can do. I haven't been back since....I can't drop the class, it's a 400-level class, and I need it to graduate, and it isn't offered any other time this year, and I can't change sections, but I just about --- I mean, I can't sit through a quarter of having this guy laughing at me up there in front of the class, and perhaps telling all of his friends and frat brothers and everything else, and it's just, I mean, it really bothers me, I'm so embarrassed about it. And there seems like there is nothing I can do.

ROLE 9 Well, you see, I got this girl pregnant and I am not going to marry her. I want some information about abortions because I feel a certain responsibility. You see, I don't know if I love her or not and I got to be sure before I start thinking about marrying her -- I mean, about marrying anyone.

ROLE 10 What should I do? My son is taking drugs, and I just know he has to. He has been acting very odd ever since his father and I got the divorce last month. It must be his father's doing. He would do anything to take my boy away from me and that father of his is always up to no good.

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ROLE 11 I'm in sort of a bind --I don't know if you can help me, but, well I've gotten very interested in my roommate's old fiancee. Since he and I have started to become friends she has been treating me very cooly. We were good friends before she moved in, too. I asked her if it bothered her, but she says no. I don't think she has the right to tell me who to see, but I don't want to jeopardize our friendship.

ROLE 12 I guess you don't deal in this area, but I couldn't think of anybody else to call. I live in a dorm and I have been here a year now. My roommate and I have gone on a diet together. She is built like Racquel Welch, but I've got about 50 pounds to go. She's always getting me dates with gorgeous guys, but they never call back. I want to meet a nice boy: I guess one who doesn't mind fat.

ROLE 13 I want to quit school; I'm tired of being broke and having a rundown car and a crappy apartment. I want some of the things that I feel I deserve. Even when I graduate I won't be able to get any better job than I can right now. I don't see why I should waste another year. I do enjoy studying and learning, but I can't stand the constant hassle with money. I'm here on financial aid so if I quit I probably won't ever be able to come back. I'm also tired of this place. I figure if I have to stay here another year, I'll never make it.

ROLE 14 Hi! I am going to have a baby! Don't get shook. I am happily married, have been for four years and we have been trying so hard for so long. It finally worked. I am pregnant! Since I am sure now, I'm going to tell Jerry tonight over a candlelight dinner, his favorite dish and the whole works. I'm so happy, isn't it fantastic????

ROLE 15 I'm having problems with my boyfriend. We've been getting pretty intimate lately, and all that is left is going all the way. I'm not sure it's what I want to do because I've always wanted to be a virgin when I got married, but it's awfully tempting. I've been brought up to believe that sex outside of marriage is wrong, but how can it be wrong when I love him so much? He doesn't understand this and is getting very impatient because I won't go all the way. I'm afraid I'll lose him if I don't, but I'm afraid I'll hate myself if I do.

ROLE 16 I've been running into some people that are really messing me up. It seems like for the last few months I have been meeting nothing but Jesus freaks, the type that say "hi" and then ask if you have accepted Christ. The first few times it was interesting to rap with them, but now I'm getting tired of it, but I don't know how to politely tell them to shut up. They always end up with a rap about how stupid people are who won't accept Christ and how we were really missing out on something. At the same time, I am not sure I want to make the committment, and I hate having it constantly shoved down my throat.

ROLE 17 — I'll tell ya what! I'm really ready to do something drastic. I mean bad. The chief at the office is giving me a bad time all the time for nothing. I'm trying to learn my job well and I'm trying to hold down an outside job, you know, moonlighting; and I'm tired all the time, and well, I guess I'm just in a circle. Prices are still going up and I can't keep up. I'm afraid of using drugs, but for some reason, I'm not afraid of death; and as a matter fact, dying seems easier than living today. What am I gonna do, man? I need some help.

ROLE 18 — You see, I've, uh, got this gun here in front of me, and, uh, it's loaded; I've got to leave this world, man. There's nothing here for me. My girl friend's run away with some other dude, and, like, we were ready to go through with marrying. That bitch! That dumb bitch. But I'll show her. My gun is loaded and, well, it's just ready. I'm callin' you just to tell somebody; but that's all. That's it. Goodbye.

ROLE 19 — I didn't like the guy you referred me to. He wasn't a guy, he turned out to be a girl---a female doctor. I mean, she ain't gonna examine this body of mine. I ain't afraid of girls now. Don't get me wrong. But this women's lib stuff has gone a bit too far. Your service goes for that stuff, huh? Now either give me a male doctor or take your counseling service and cram it!

ROLE 20 — Hi. I'm a bit older than the normal caller, I think, but it's about my daughter I'm calling about. I'm embarrassed to talk about it. (silence)..... She's queer. I mean, she told me. And I was so shocked I hit her. And then I cried. And she ran away. My God, My God, oh My God, what am I going to do with her--put her away or move to another state?! Tell me, please. Did I go wrong somewhere in raising her?

ROLE 21 — Help me please. (silence).....!
Help me...(silence)! I've taken some pills to die and now I don't want to die....! I'm not sure where I am...and what I took. All I can see it a bridge and some blinking colored lights.

ROLE 22 — I'm not sure if you can help me, but I've got this problem--Well, some people think it's a problem. I don't think so; but, I'm gay. You know, I'm a guy with boyfriends. I like girls, too; but it seems that if anybody finds out about my situation, my job is over with, my friends will leave me; you know, it will be hard to live from one day to the next. They just can't accept changes. They don't understand!

ROLE 23 — (Woman) Hey! I've got this friend and she's in trouble. I know she is. She drinks a lot and wants to stop because her husband and kids are ready to leave me, I mean her. Who can I suggest for her to go see?

NOTE: PAGES 1232 + 1233 HAVE BEEN DELETED; HOWEVER ALL MATERIAL IS INCLUDED.

1234

ROLE 24 My friends think I'm queer; I mean gay. They say I walk and act like a woman and that makes me a homo. Like, I know I've got some female tendencies--like I walk sort of feminine, and I like some things that women like, but I've never had sex with a guy and don't intend to, but I'm not sure whether I'm queer or not. What should I do?

ROLE 25 I need some information. I made it with this guy last weekend and now it looks like I've got some kind of disease or something. It's really awful, and uncomfortable. And I can't talk to my parents. And this guy he's gone to another state for a year or more and my boyfriend will be really pissed off. We're supposed to go out tomorrow night. And I don't want to tell him either.

ROLE 26 My parents are always fighting. I can't go home and be comfortable because they're either fussing at me or at each other or at my brother and sister or even the dog. Man it's miserable. They don't trust nobody. It makes me want to run away.

ROLE 27 (Very fast) I'm having a really neat trip. Like I'm enermetic and really want to work hard and can't lay down and get any sleep. I'm starting to get nervous and very anxious now; feels like I've been up a long time; can't remember how long. I think I took some bennies, but I don't know what they were for sure. Tell me what to bring me down. We started smokin dope.

ROLE 28 (Female) ...Hysterically... Please help me! I was walking out in the country and these two guys stopped and picked me up in their car and took me somewhere and, and...well, they raped me. And I just walked back from where they dumped me and found this phone and...what am I going to do? What am I going to do?

ROLE 29 I've just been had. I just paid some guys some big money for a TV set; they said they would go get the set and bring it to my house. It's been six hours now. That's $350.00. Do you know how much money that is? Those crooks. And they said it was a $700.00 set!

ROLE 30 Oh--I guess I must've had the wrong number. I was, uh,...trying to get...oh yes--MacDonald's. Yes, that's it; Macdonald's. Uh, can ya give me that number for sure? I really need to have that number. (Silence.)....Are you there?

65?

1235

PART II - TEACHING GUIDE

The use of this lesson plan is restricted to a controlled access environment.

1. The Crisis Intervention/Telephone Counseling Practicum emphasizes student learning and evaluation of their skills and techniques in dealing with life crisis situations. The crisis will be role-played in two types of situations: 1) Walk-in crisis in which the client actually enters the role-played social actions office, and is dealt with on a face-to-face basis; and 2) Telephone "hotline" crisis in which the client is phoning in through a telephone counseling service, and the individual is dealt with using all the rules which apply to an Air Force crisis counseling service. Stress that social actions counselors may have to cope with client life crises at any time. It is very important to know what to do to help the clients get the help they need when they are confronted with a crisis.

2. Throughout the practicum, intersperse telephone and walk-in roles, so that students get used to dealing with client problems as they would in their base-level social actions office.

3. Student role-playing counseling sessions consist of having one student volunteer to be the counselor and one the client. Brief the student client using the attached role sheet. Allow students to read only the role they are to play. Ask student clients to become aware of their feelings during the session, and act toward the counselor as they would based on the feelings they have at that moment. Stress realism. If the counselor "turns them off", then say so, hang up, or leave--just the way the client would do. If the counselor engenders cooperation, then cooperate, etc. Clients should use their imagination, experience, real-life problems, and feelings to enrich the roles and make them real.

4. During the 5 to 20 minute sessions the other students should take notes in order to critique the counselor's actions and discuss what they would do if they were in the counselor's situation. Spend the next 5-10 minutes critiquing the session. Encourage maximum participation of students. When critiquing use the Crisis Intervention/Telephone Counseling Progress Checklist. Correct and suggest better counseling techniques, better methods to deal with the crisis situations, and insure the correct policy content information provided to the client is correct. REINFORCE GOOD COUNSELOR BEHAVIOR. Also reinforce those who play good client roles.

5. Devote approximately one-half of the practicum to practice sessions. Although you use the Crisis Intervention/Telephone Counseling Progress Checklist, PC IV-3-16-C, provide a duplicate copy to give the student feedback. Primary emphasis is upon learning the skills and techniques. Be creative in teaching these techniques to students. Stop the action in the middle of the counseling session if necessary. Ask clients how they feel about what the counselor is doing. Ask the counselors where they intend to go with a particular line of questioning. Ask the group if

they can think of a better method. Switch the client and counselor roles. Assume the counselor's role, yourself, and demonstrate the technique yourself. Insure the practice sessions are a learning experience. Normally, the individual role-playing sessions are from 5-20 minutes with a critique following.

6. The other half of the practicum should be devoted to evaluation sessions. Although the evaluations should be a little more formal, remind the students to keep the attitude that they are learning experiences. Some students may need more time than others to learn the skills and techniques necessary to do well on the job. In the evaluation sessions normally ask the counselor to operate on his/her own, as they will have to do when they return to their base. They sink or swim. After the session, use the progress checklist to give them feedback, and give them a carbon copy to retain for self-improvement

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END-OF-DAY SUMMARY

SUMMARY

1. Restate objectives of the lesson.

2. Emphasize the areas of major importance.

3. Use oral questions to determine areas to be retaught.

ASSIGNMENT

1. Identify study material.

2. Give cause for students to study assignment.

3. Mention method of study.

INTRODUCTION TO NEW DAY'S WORK

1. Check on accomplishment of complementary technical training or other assignment.

2. Arouse student interest (attention and motivation).

3. Review items of major importance (review).

4. State objectives to be covered on this particular day (overview).

5. Continue presentation, beginning where it ended the previous day.

ATTACHMENT 1

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CRISIS INTERVENTION/TELEPHONE COUNSELING ROLE

ROLE 1 Telephone

What kind of God damned town do you have here? Jesus, everywhere I go, if it's not a bunch of faggots and queers swishing around, it's the Coons and Spics reuniting. What the hell kind of place is this anyway? And I expect a decent answer.

ROLE 2 Telephone

I would like your opinion, given this choice. I purchased a tab of acid from a friend of mine. He said it was very mild, a good one for those who have never tripped before. I have always wanted to try LSD once. I have heard all about the controversies, and so I believe I know what I'm getting into. However, I would still like to hear what some other people have to say about it. I've made the transition to a freak almost. The acid is the last stage; so, can you tell me what acid is all about?

ROLE 3 Telephone

I have a problem. It's about this guy. You see, I am gay and I'm having a love quarrel. John, that's the name of my lover, is more straight than gay. He has recently met this girl who is more exciting than I am -- so he says, anyway. If he continues seeing this girl, it will only mean heartbreak for me. I've never thought about suicide before now, but every day just brings more and more confusion. People say I'm strange, and maybe everybody would be just as happy if I just happened to disappear.

ROLE 4 Walk-In

(Sobbing) I've got a terrible problem, and I need some answers pretty quick. If your fiance was away, like going to another school, and you got pregnant by someone you thought was a good friend, how would you tell your fiance the situation? I mean, I'm getting an abortion, so that's all taken care of. He doesn't ever need to know about it, or anything like that. But, I feel I've got a responsibility to tell him about the situation. I think he deserves to know about what went on and what a rat I am, but I don't know how to tell him. I just don't know.

ATTACHMENT 2

ROLE 5 Telephone

You had said you were interested in other people's problems, so, I'm gonna lay a heavy one on you. I've been dating this black chick for about three months now. There wouldn't be a problem, except that I'm white. I've been raised to see no difference between white and black, and I believe that I exhibit this point of view myself, now, as an adult. The problem is with my chick, who somehow believes that I should see a difference between us. She is always testing me to see if I have yet become a racial bigot. I am getting tired of this, but I feel something special for this chick. As though matters weren't bad enough, she is now pregnant. I believe it is probably my kid, but there always exists the chance that it could be one of her black brother's. So, here is the problem; now, what is the answer?

ROLE 6 Telephone

I'm so happy, I just don't know what to do. I went out with this guy that I've had my eye on since high school. It was so neat! He acts absolutely in love with me. He didn't say anything about calling again, but I'm sure he will.

ROLE 7 Walk-In

I am flunking a class and I can't afford to flunk it. The instructor is really understanding, but I just can't grasp the material. He spends all kinds of time with me, but it doesn't seem to do any good. I need the credits now in order to graduate. I can't get them later, because I'm taking maximum loads all the way until graduation. I've considered really going all out and cheating to get through the class, but I can't really justify it. I've got to have the credits, one way or another, but I don't know what to do. What would you do in my case?

ROLE 8 Walk-In

Yeah -- um -- I have this problem, and I don't know what anybody's going to do about it, because it's not the sort of thing that has an answer. But -- oh, a couple of months ago, I met this guy at the VIP and, I don't know, we sort of hit it off and so I ended up going over to his apartment. And -- oh, we drank a little over there, and smoked a little, and I ended up getting really, really drunk and really stoned. And, I ended up going to bed with him. And -- well -- that was OK. I mean, I didn't even hear from him after that, and that didn't really bother me, because, well, you

1240

know, I was kind of embarrassed about it. I mean, I don't usually do things like that. But -- I walked into my discussion group for one of my upper-division classes this quarter, and lo and behold, he's a grad student, and he's teaching the discussion group! I just about died of embarrassment when I walked in. But -- I mean, there's nothing I can do. I haven't been back since. I can't drop the class. It's a 400-level class, and I need it to graduate, and it isn't offered any other time this year, and I can't change sections. But, I just about -- I mean, I can't sit through a quarter of having this guy laughing at me up there in front of the class, and perhaps telling all of his friends and frat brothers, and everything else. And it's just -- I mean, it really bothers me. I'm so embarrassed about it. And there seems like there is nothing I can do.

ROLE 9 Walk-In

Well, you see, I got this girl pregnant, and I am not going to marry her. I want some information about abortions, because I feel a certain responsibility. You see, I don't know if I love her or not, and I got to be sure before I start thinking about marrying her -- I mean, about marrying anyone.

ROLE 10 Walk-In

What should I do? My son is taking drugs, and I just know he has to. He has been acting very odd ever since his father and I got the divorce last month. It must be his father's doing. He would do anything to take my boy away from me, and that father of his is always up to no good.

ROLE 11 Walk-In

I'm in sort of a bind. I don't know if you can help me, but, well, I've gotten very interested in my roommate's old fiancee. Since he and I have started to become friends, she has been treating me very cooly. We were good friends before she moved in, too. I asked her if it bothered her, but she says no. I don't think she has the right to tell me who to see, but I don't want to jeopardize our friendship.

ROLE 12 Telephone

I guess you don't deal in this area, but I couldn't think of anybody else to call. I live in a dorm, and I have been here a year now. My roommate and I have gone on a diet together. She is

built like Racquel Welch, but I've got about 50 pounds to go. She's always getting me dates with gorgeous guys, but they never call back. I want to meet a nice boy; I guess one who doesn't mind fat.

ROLE 13 Telephone

I want to quit school. I'm tired of being broke and having a run-down car and a crappy apartment. I want some of the things that I feel I deserve. Even when I graduate, I won't be able to get any better job than I can right now. I don't see why I should waste another year. I do enjoy studying and learning, but I can't stand the constant hassle with money. I'm here on financial aid, so if I quit, I probably won't ever be able to come back. I'm also tired of this place. I figure if I have to stay here another year, I'll never make it.

ROLE 14 Telephone

Hi! I'm going to have a baby! Don't get shook. I am happily married, and have been for four years, and we have been trying so hard for so long. It finally worked. I am pregnant! Since I'm sure now, I'm going to tell Jerry tonight, over a candlelight dinner, his favorite dish, and the whole works. I'm so happy, isn't it fantastic????

ROLE 15 Walk-In

I'm having problems with my boyfriend. We've been getting pretty intimate lately, and all that is left is going all the way. I'm not sure it's what I want to do, because I've always wanted to be a virgin when I got married, but it's awfully tempting. I've been brought up to believe that sex outside of marriage is wrong, but how can it be wrong, when I love him so much? He doesn't understand this, and is getting very impatient because I won't go all the way. I'm afraid I'll lose him if I don't, but I'm afraid I'll hate myself if I do.

ROLE 16 Walk-In

I've been running into some people who are really messing me up. It seems like for the last few months I have been meeting nothing but Jesus freaks -- the type who say "hi" and then ask if you have accepted Christ. The first few times, it was interesting to "rap" with them, but now I'm getting tired of it, but I don't know how to politely tell them to "shut up." They always end up with a "rap"

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about how stupid people are who won't accept Christ, and how we were really missing out on something. At the same time, I am not sure I want to make the commitment, and I hate having it constantly shoved down my throat.

ROLE 17 Telephone

I'll tell ya what! I'm really ready to do something drastic. I mean bad. The chief at the office is giving me a bad time all the time for nothing. I'm trying to learn my job well, and I'm trying to hold down an outside job -- you know, moonlighting. And, I'm tired all the time, and, well, I guess I'm just in a circle. Prices are still going up, and I can't keep up. I'm afraid of using drugs, but for some reason, I'm not afraid of death. And, as a matter of fact, dying seems easier than living today. What am I gonna do, man? I need some help.

ROLE 18 Telephone

You see -- I've -- uh -- got this gun here in front of me. And -- uh -- it's loaded. I've got to leave this world, man. There's nothing here for me. My girlfriend's run away with some other dude, and, like, we were ready to go through with marrying. That bitch! That dumb bitch! But I'll show her. My gun is loaded and, well, it's just ready. I'm callin' you just to tell somebody, but that's all. That's it. Goodbye.

ROLE 19 Walk-In

I didn't like the guy you referred me to. He wasn't a guy. He turned out to be a girl -- a female doctor. I mean, she ain't gonna examine this body of mine. I ain't afraid of girls now. Don't get me wrong. But, this women's lib stuff has gone a bit too far. Your service goes for that stuff, huh? Now, either give me a male doctor, or take your counseling service and cram it!

ROLE 20 Telephone

Hi. I'm a bit older than the normal caller, I think, but its my daughter I'm calling about. I'm embarrassed to talk about it. (Silence.) She's queer. I mean, she told me. And I was so shoked, I hit her. And then I cried. And she ran away. My God, my God, oh, my God, what am I going to do with her -- put her away or move to another state?! Tell me, please. Did I go wrong somewhere in raising her?

ROLE 21 Telephone

Help me, please. (Silence!) Help me! (Silence!) I've taken some pills to die, and now I don't want to die!!! I'm not sure where I am -- or what I took. All I can see is a bridge and some blinking colored lights.

ROLE 22 Walk-In

I'm not sure if you can help me, but I've got this problem. Well -- some people think it's a problem. I don't think so; but, I'm gay. You know, I'm a guy with boyfriends. I like girls, too; but, it seems that if anybody finds out about my situation, my job is over with, and my friends will leave me. You know, it will be hard to live from one day to the next. They just can't accept changes. They don't understand!

ROLE 23 Telephone

(Woman) Hey! I've got this friend, and she's in trouble. I know she is. She drinks a lot, and wants to stop, because her husband and kids are ready to leave me, I mean her. Who can I suggest for her to go see?

ROLE 24 Walk-In

My friends think I'm queer -- I mean gay. They say I walk and act like a woman...and that makes me a homo. Like, I know I've got some female tendencies -- like I walk sort of feminine, and I like some things that women like. But I've never had sex with a guy, and don't intend to; but, I'm not sure whether I'm queer or not. What should I do?

ROLE 25 Walk-In

I need some information. I made it with this guy last weekend, and now it looks like I've got some kind of disease or something. It's really awful, and uncomfortable. And I can't talk to my parents. And this guy has gone to another state for a year or more. My boyfriend will really be pissed off. We're supposed to go out tomorrow night. And I don't want to tell him either.

ROLE 26 Walk-In

My parents are always fighting. I can't go home and be comfortable because they're either fussing at me or at each other or at my

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brother and sister or even the dog. Man, it's miserable. They don't trust anybody. It makes me want to run away.

ROLE 27 Telephone

(Very fast.) I'm having a really neat trip. Like I'm energetic and really want to work hard, and can't lay down and get any sleep. I'm starting to get nervous and very anxious now; feels like I've been up a long time; don't remember how long. I think I took some bennies, but I don't know what they were for sure. Tell me what to take to bring me down. We started smoking dope.

ROLE 28 Telephone

(Female) (Hysterically.) Please help me! I was walking out in the country, and these two guys stopped and picked me up in their car and took me somewhere. And -- and -- well -- they raped me. And I just walked back from where they dumped me and found this phone -- and -- what am I going to do? What am I going to do?

ROLE 29 Walk-In

I've just been had. I just paid some guys some big money for a TV set. They said they would go get the set and bring it to my house. It's been six hours now. That's $350.00. Do you know how much money that is? Those crooks! And they said it was a $700.00 set!

ROLE 30 Telephone

Oh -- I guess I must have gotten the wrong number. I was, uh -- trying to get -- oh, yes, MacDonald's. Yes, that's it -- MacDonald's. Uh -- can ya give me that number for sure? I really need to have that number. (Silence.) Are you there?

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Technical Training

Drug and Alcohol Abuse Control

Counseling Techniques

CRISIS INTERVENTION/TELEPHONE COUNSELING

1 August 1978

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30ZR7364B-III-2-1
1 August 1978

Counseling Techniques

CRISIS INTERVENTION/TELEPHONE COUNSELING

OBJECTIVE

Identify crisis intervention techniques associated with drug/alcohol clients.

Identify crisis intervention and telephone counseling techniques associated with client and/or caller problems.

INTRODUCTION

This unit of instruction covers the definitions of personal crisis and crisis intervention, the goal of a counselor in a crisis intervention situation, and counseling techniques for various crisis, including drug overdose, potential suicides, rapes, problem pregnancies, child abuse, runaways, homosexuals, and emergency medical. In addition, the requirements for establishing a base telephone counseling service and techniques for specific telephone calls that could possibly turn into a crisis are also covered. The specific learning (criterion) objective(s) associated with each major section of this study guide and workbook (SW) will lead off the applicable section.

INFORMATION

CRISIS AND SITUATIONAL REALITIES

In the quiet hours of the very early morning, the telephone suddenly cuts dramatically through the peacefulness with its loud ring. You sleepily lift the receiver cautiously and anxiously, not sure what the call will bring. A woman frantically speaks.

"I'm glad you finally answered. I really need to talk to someone fast. I've been lying here awake all night long thinking. You see, my husband died two weeks ago — you know — heart attack. And we had made an agreement that when one of us died, the other one would follow; and . . . well . . . I'm just not ready to die yet. I've got all these pills right in front of me ready to take, but I'm not ready. I just can't do it. I loved my husband very much, and never broke a promise to him! What can I do? Can you help me? . . . . Please!!"

A call such as this requires a particular skill on the part of the answerer. This scene could have been a telephone crisis center designed to handle calls such as this, with adequately trained staff members who can deal with anything from a frantic parent concerned about a child's drug use to the suicide caller. Or, it

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could be in your Social Actions office, or even your residence. Wherever it is, whenever the call comes in to you, there is a need for intervention; and, simply by virtue of the call being answered, there is need for action. As Social Actions staff members, you possibly will be responsible at sometime in your career for handling a crisis. Whether it be in your drug "hot line," the call to your office, walking around on base meeting people, or all of these, there involves someone who needs help. The answer must be immediate, accurate, judgmental in action, and, above all, the result of clear thinking. By understanding the definition of a crisis, the characteristics of a person in a crisis, and general counseling techniques for crisis intervention, you will be better prepared to handle whatever crisis that may confront you.

DEFINITIONS

WEBSTER'S DICTIONARY: "A turning point in the midst of a situation."

GERALD CAPLAN: "The disorganization of an individual when faced with a problem which cannot be solved quickly by the individual's normal range of problem-solving mechanisms." (Farberow)

AIR FORCE: "A situation in which an individual feels his/her problem is of such magnitude, he/she cannot handle it him/herself. He/she establishes an immediate need for help." (Air Force Regulation (AFR) 30-2)

Handling the Crisis

Most persons will be able to handle unusual or crisis situations through normal coping mechanisms, imaginative, creative thinking, and/or a willingness to try a new or unfamiliar approach to problem solving. If these normal resources work, fine. Not only has there been a problem resolved, but also newly-acquired problem-solving methods for future use, maturation, and emotional growth have resulted. If they don't work, however, the person still needs to act on the immediate crisis. You might be the next resource available during this person's period of emotional instability. In order to handle the situation with success, you must be able to recognize the situational realities involved in a crisis.

Situational Realities

SITUATIONAL ENVIRONMENT. ("A situation. . .") The immediate situation with which you are concerned is not necessarily a hazard. It could possibly be considered either as a danger or as an opportunity. (Berg, 1969) It is a time of judgment and decision that reveals strengths and weaknesses both to self and to others.

Danger. The crisis situation poses a threat to the individual's sense of self. The person is judging self as the crisis is experienced, which might add additional aspects to the already-existing crisis. The well-being of the individual is being threatened, and this is interpreted as a danger.

Opportunity. The potential for a painful, yet positive, growth experience exists in practically every crisis. As an individual judges the situation and the self throughout the crisis, other persons are also judging the performance. As decisions are made and acted upon, the results offer growth, even in those cases where the decision might not be the correct one for that crisis.

CLIENT.(" . . . in which an individual feels his/her problem is of such magnitude. . . .") As the situation is considered to be either a danger or an opportunity, it is existing as very real to the person faced with the decisions. The characteristics of the person in crisis cover a wide range of feeling experiences. (Berg, 1970; Farberow)

Stress. Emotionally, the person has reached coping limits and doesn't know which way to turn, or even whether to turn at all. All resources seem to have been exhausted, people are watching, and decisions still have to be made because the crisis is still very much in existence. Something must change.

Anxiety. The most common feeling of persons in a crisis is that of anxiety. The feeling of being threatened exists, and anxiety in its helpful stage mobilizes the person against the threat. In its harful stage, anxiety produces almost a self-defeating behavior, restricting any creative or imaginative approach to problem solving.

Confusion. Anxiety produces a state of confusion through poor judgment, leading to wrong decisions or lack of decisions, and the inability to remove self from the problem to consider solutions.

Helplessness. Individuals develop coping mechanisms through experiences and hard work. When suddenly an unfamiliar

situation exists, the rug seems to have been pulled out from under them, and there is nothing to grab for support.

Shame. As we grow up, we are taught a certain amount of independence in problem solving. We are taught to develop our own abilities to cope in situations which might arise. Suddenly, in a situation which cannot be handled in a competent manner, a dependence on other persons is necessary. This has a tendency to cause shame as feelings of incompetence and dependence become real.

Ambivalence. The person is struggling with extremes. For instance, independent versus dependence, and controlling emotions versus losing control. This is seen in the potential suicide with the person wanting to continue to live and yet wanting to die.

Anger. The person in a crisis experiencing anger usually finds it directed toward self for being unable to control the situation, or toward another person or event as the cause of the situation. Many times, however, anger may be hidden behind the other more blatant feelings.

Desperation. The person knows that something needs to be done in order to work through the crisis, but is not exactly sure what resources are available and how to use them.

The crisis situation appears to be so big that facing it alone and not being able to work through it has caused the individual's self-esteem to decrease or even disappear, and has left the person extremely vulnerable. There is a danger in this in the form of increased suggestibility that might cause a person to respond immediately to anything. Yet, if the counselor is thorough and knowledgeable, good suggestions can assist the individual to work through the crisis with safe and healthy results.

COPING WITH CRISIS (". . . he/she cannot handle it by him/herself . . . ."). Every individual has a coping threshold below which they are able to successfully deal with challenges. (Berg, 1970) This threshold is dynamic and changes constantly through personality, environment, interpersonal skills, and new challenges.

Identifies threshold. When the individual faces a crisis, the coping threshold is identified, and the person is either able to cope or not to cope.

Identifies problem-solving resources. If the threshold is exceeded, the individual recognizes a new situation and that

normal resources at hand are not going to work. The next step is to seek primary resources. These are persons or behavioral patterns that are familiar and have, in the past, been helpful for coping, including alcohol, calling a parent or close friend, keeping busy on a project, or taking a long hike. If these fail, the person must begin to seek other secondary resources who are less well known, such as a bartender, cab driver, elevator operator, teacher, minister, or someone at a social agency who might be directly involved with the problem. Tertiary resources come into play as secondary resources fail, and are generally considered as "last-chance" or "end-of-the-line" resources. These strange and unfamiliar persons or agencies are far removed from the familiar and usually are introduced to the person in the most advanced state of the crisis. These include hospital emergency rooms, police, telephone crisis lines, drug abuse centers, free clinics, and Social Actions offices. (Berg, 1970)

DETERMINATION OF CRISIS (". . . . He/she establishes an immediate need for help. . . ." The person in crisis determines the need for help, after considering all available resources, not the counselor.

A crisis situation is time-limited, an important consideration for the counselor. No one can remain in a crisis indefinitely. A few days is considered an average time, with proper intervention and assistance to the individual. In rare cases, a crisis may last for weeks. Caplan suggests "a maximum duration of six weeks." (Berg, 1970) The cause for the crisis, however, could exist indefinitely. In the crisis situation, the primary need is for immediate action, not so much long-term action.

The person experiencing the crisis is also experiencing rapid and dynamic changes within. Many have occurred before you are in contact, many are occurring while in contact, and many will obviously continue to occur after the crisis is resolved. Therefore, once the crisis is over, the real work begins, both for the counselor and the person who has experienced the crisis.

Exercise I

Complete the following exercise.

1. Distinguish between the dangers and the opportunities of a crisis.

2. What feelings are generally being experienced by the person in crisis?

3. Explain ambivalence with respect to a person in crisis.

4. What are tertiary resources? Give some examples.

CRISIS INTERVENTION

Definitions

RESNIK/REUBEN. "Having access to the person in a crisis at the exact time when minimum intervention can have a maximum effect on a person's life." (Parad, 1975)

FARBEROW/HELIG/LITMAN. "A form of active, focused emotional first-aid in order to stimulate the client's own problem-solving resources." (Farberow, Jones, 1968)

AIR FORCE. "Helping someone with a problem, regardless of how big or small it may be, at the time the person has an immediate need for help." (AFR 30-2)

INTERVENTION. The person in the crisis situation who has reached out for help is behaving from a feeling state that is real and somewhat threatening. There are expectations: (1) That there is an answer; and, (2) That the intervenor or counselor is interested and willing to help.

Exercise II

Complete the following exercise.

1. How big does a problem have to be before help should be offered?

2. When is the help needed?

CRISIS INTERVENTION GOAL AND COUNSELING TECHNIQUES

Goal of Crisis Intervention

"To develop a relationship through which the person can sort out his/her thoughts and feelings, and eventually act on his/her decision with his/her own problem-solving resources." (Berg, 1970)

Counseling Techniques

RELATIONSHIP ("To develop a relationship. . . .") Giving yourself. This is simply making all of your attention and energies and concentration available to the person who has reached out for your help. It is relating your concern and desire to help by showing an unconditional, positive regard for the caller. By totally accepting the person without any conditions whatsoever, without being judgmental or moralizing or labeling, but complete acceptance, this is the beginning of total giving.

CREATIVE LISTENING. Recognizing what feelings the person in crisis might be experiencing, realize that it was a risk for that person to reach out. The person needed to be heard, and your encouragement of that person to talk will be enhanced if you listen to the story in his/her own words. If there is confusion and incongruence, expect this, but don't be afraid to feel confused and to tell the person you don't understand. Use reflective questions to clarify or simply state: "I didn't understand that last statement. Could you repeat it again, please." The larger the arc of distortion, the longer it takes to get to an answer.

ORGANIZATION. (". . . through which the person can sort out his/her thoughts and feelings. . .")

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CONTROL. By remaining calm and self-assured in your role as a counselor, chances are good that this will help the person in crisis gain more self-confidence and, therefore, more control of the situation. By asking probing questions, you might be able to get through to the real problems and assist the person to begin organizing the problems along with the solutions, in order to work through the immediate crisis. Encouraging the person to list solutions, rather than your listing them, would assist him/her in assuming ownership of the problem and solutions. If there are some solutions that "just won't work; I know they won't!," encouragement to try them anyway, by the counselor, might be just the right solution needed. The person will never know unless he/she tries them.

ACTING OUT. (". . . and eventually act on his/her decisions with his/her problem-solving resources . . .") When encouraging the person to go ahead and act on the solutions that he/she identified, remind him/her that the list of solutions didn't come from the counselor, but from the individual with whom you are talking. Following through with them will add more ownership and confidence and will also add to the person's list of resources for future situations. If referral assistance is necessary, the counselor must refer in such a manner as not to give the impression he/she is avoiding helping the individual. Tactful, timely, appropriate, and thought-out referral will aid in the successful crisis intervention. Some referral techniques include:

Multiple Referrals. Do not list several choices for referral. The individual is already saturated with thoughts and needs and feelings and confusion. Adding to this confusion with several more "choices" would not be helpful.

Correct Information. Before the conversation is over, insure the person has the correct name, address, and telephone number of the person or agency to whom you have referred him/her. Simply ask the person to repeat the information to you.

Contact. Encourage the person to make contact with the referral agency, rather than your doing it. This adds to his/her ownership of problem solution.

Cost. If time permits, find out what the person can afford before referring, or otherwise you might soon have another crisis on your hands. Be reasonable and refer within limits of income.

Under Care. If a person is already under care with an agency or individual in the community, attempt to get the person

to use the same agency. This should not be forced, however. Free choice is still the person's right.

Continued Contact. Encourage the person to continue contact with your organization. This will allow closure to the situation as far as the counselor and the individual are concerned. It will also show the person you are interested in him/her by wanting to have other contact.

Follow-Up. Follow-up with the referral agency will allow you to build your referral list with credible, responsible agencies. If an agency does not serve your client as you feel he/she should have been served, discuss the incident with the agency director before dropping the agency name from your referral list.

Exercise III

Complete the following exercise.

1. Why is it important to actively listen to the person in crisis?

2. When should the counselor interrupt or ask questions?

3. How can the counselor assist the person to gain control of the situation?

4. List several referral techniques.

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COUNSELOR FEELINGS

Anxiety

INADEQUATE. The counselor who always feels as if he/she should be someone else, such as a doctor or psychiatrist, or should have read something to cover a situation, but, ". . . now, it's too late," will probably be more concerned with self than with listening to and helping the person who needs help. (Lamb, 1970)

INCREASED ANXIETY. The anxiety of the counselor could be transmitted to the person in crisis, who will, in turn, have increased anxiety, causing the crisis situation to appear worse than it actually is. The person might then be encouraged to follow through with a threat, due to his/her higher anxiety level inspired by the counselor.

CREDIBILITY. The counselor who allows anxiety to control him/her stands a chance of reducing the credibility of his/her service or the counseling service to a considerable degree.

REINFORCEMENT. If the counselor allows feelings of anger to develop toward the object of the individual's anger, it possibly could reinforce the individual's anger and prevent problem solution.

TERMINATE RELATIONSHIP. If the counselor is existing under the concept that his/her answers are the only ones, and if he/she can't think of an answer, there is none, the individual in crisis might express anger because he/she is not getting help. The counselor who gets angry in return stands the chance of losing the person and of terminating the relationship.

PREVENTS CREATIVE APPROACH. The counselor who allows anger to dominate also prevents a creative approach on the part of the person in crisis to look for solutions to the problem.

Confusion

WRONG SOLUTIONS. The counselor who is confused and does not attempt to clarify confusion will be wasting time and, perhaps, working for solutions to the wrong problems.

ADMIT. By admitting rather than covering up confusion, the counselor is not criticizing the person in crisis, but merely saying, "I'm human and I don't understand. I hear . . . and . . .; which is the major concern to you?" By allowing the person to identify what he/she wants help with, action can begin toward that solution, rather than the wrong one.

Sympathy

NEGATIVE REINFORCEMENT. By the counselor continuously expressing sympathy without encouragement, the person in crisis will grow to rely on that reaction and feel it is not necessary to look for answers. Also, feeling sorry appears as if you are siding with the person, and that he/she is right in past actions, and everyone else is wrong. The need for seeking solutions is decreased.

OMNIPOTENCE. The counselor who feels he/she has to find an answer for the individual because: "I was called on!" is playing a "God-like" role. Persons are not all "loveable" in crises and don't always need sympathy and directions. Many times, all they need is to be listened to.

CAUTION. Sympathy might instill too much caution in the counselor and further prevent problem solution. If the counselor is afraid of "talking about it, or he will go through with it!," time will be wasted attempting to find something to talk about. If you are too sympathetic to talk about the problem, how will the individual be able to deal realistically with them?

PROMISES. It's easy to promise something early in the game simply to get the person to speak. But, the person remembers those promises and expects the counselor to follow through with them. Make sure you can keep those promises you make, or credibility and trust are destroyed.

Exercise IV

Complete the following exercise.

1. How is problem solution decreased by the counselor's anxiety?

2. How can confusion work for the counselor?

3. Why is too much caution bad for a counselor?

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TELEPHONE COUNSELING

Establishment of the Service (as required)

RECOMMENDATION. The establishment of a telephone counseling service should be based on a combination of sound facts. These facts should be compiled by the Drug and Alcohol Abuse Control Committee and presented to the commander. Areas to consider are listed below. (AFR 30-2)

ADVANTAGES. Counseling by telephone has the advantage of being available to everyone with no time-limit and no charge. It allows a discussion of problems to take place immediately and over a distance of miles. It encourages a one-on-one situation and dyadic communication. For persons who are dependent, it allows closeness for them, as well as for those in isolated life styles. Anonymity encourages participation. Fast support, self-assurance, and problem solving are available.

DISADVANTAGES. Even though counseling by telephone allows a one-to-one contact, it is very impersonal when talking through a mechanised instrument. It allows the person to maintain distance when personal contact might help. It prevents the counselor from seeing the caller's expressions and reactions. (Miller)

COMMUNITY SERVICE AVAILABLE. An adequate civilian community telephone counseling service which is capable of dealing with certain military problems, as well as other crises, should be considered in lieu of a full-time, on-base service. Encouraging the staffing of the civilian crisis lines with military volunteers would assist in handling some calls peculiar to the military, as well as help in furthering military-civilian relationships.

AUTOVON. If an installation or a site cannot adequately staff a telephone counseling line, authority is given for use of AUTOVON lines with a nearby base or host base with an already-existing telephone counseling service. Insure coordination is accomplished prior to use.

PROBLEMS. If there are sufficient problems involving large amounts of drug use in an area, or if other problems occur to a high degree which might potentially cause mission failure, consideration should be given for access to problem solution through telephone counseling.

General Guidelines

Insure that all areas involving local and state laws are covered.

Availability

Insure that the counseling service is staffed on a 24-hour basis. If the call is directed to a home by the base operator, insure the availability of someone at that location.

Type of Counseling

All counseling is to be done by telephone. This service is not designed to be a walk-in service or a team-response service.

Anonymity

The use of a number for the caller insures anonymity and follow-up action, and encourages the caller to be more open with the problem. It is also a good idea to use nicknames for the staff members for their own protection.

Publicity

Well-publicized telephone numbers which are easy to remember will increase business for the telephone counseling service. The top of the daily bulletin, Air Force buses, use of business cards, announcements at commanders' calls, letters to organizations, posters, fliers, etc., all are giving exposure to the service for your base.

Records

Records, using the identification number, should be maintained to allow for follow-up action, appropriate closure, and staff training.

Referral

It is essential that a system of referral be developed in order to allow a smooth transition from your services to the referral agency. The person who is needing assistance does not need to be exposed to inefficient referral techniques. An appropriate referral list includes adequately-identified services available for specific problem areas, telephone numbers, addresses, costs, and the willingness of the agency to accept a referral. Obviously,

prior coordination should be completed before referrals are made to an agency.

Contact

The telephone counseling service which encourages follow-on, continued contact proves to the person you are interested. It also allows for appropriate progress checks, closure, and staff training material.

Confidentiality

Don't make promises of confidentiality you cannot hold to, such as immunity, privileged communication, etc. Legal actions might require you to reveal information which you promised you would not reveal.

Equipment

Equipment and facilities which meet your local needs are a must if you are to provide the service to your base that you are expected to.

A minimum of two telephones with patching capability is suggested. This would allow back-up service and the ability to patch in with a trained professional who might specialize in one particular type of crisis intervention. After-duty-hours switchboard service and record-a-message might also be considered.

Security

The location of the telephone center is generally not revealed. This prevents distractions from telephone counseling duty, such as friends dropping in, and offers protection for the counseling staff.

Forms

Preprinted forms enable smooth administration of a counseling service. This could include volunteer applications, work schedules, and forms for recording the calls. These forms would allow easy progress checks, closures, and filing for staff training.

Resource Directory

This includes happenings on- and off-base, such as clubs, theaters, special concerts, etc. Having this information available

could possibly help in establishing credibility, because you know what is happening in the area. In addition, this directory includes on- and off-base offices and telephone numbers for easy referral when time is crucial. Other crisis line telephone numbers would also be included.

Information

Current books, pamphlets, and research data on the drug scene and alcohol scene might prove to be helpful. The Physician's Desk Reference (PDR) and poison antidote lists should be included. Additionally, current local and Air Force policies should be maintained.

Files

A file established, by number, will allow progress checks, follow-on support, and staff training. This should be kept under lock and key to insure no information is released, even though names are not used.

Message Board

A board such as this allows information to be disseminated to staff members which might assist them in their work on whatever shift they might be serving. This would include policy changes, new telephone numbers, new local or Air Force policy changes, new research data available, etc.

Exercise V

Complete the following exercise.

1. Describe several areas to consider when recommending a telephone counseling service.

2. Assume you were to establish a telephone counseling service on your base. What equipment and facilities would you need?

3. How does the filing system help in staff training?

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TELEPHONE COUNSELING STAFF

Staff Members

APPOINTEES. These persons should be either telephone counselors or back-up support for referrals. They include staff judge advocate (SJA), medical service personnel, chaplains, personal affairs personnel, etc. Also, include anyone who has an interest in and experience with substance-abuse problems.

VOLUNTEERS. Agencies and councils on base, looking for community service projects, offer excellent resources for volunteers. Such groups as chapel organizations, human relations council (HRC) members, Noncommissioned Officers' (NCOs')/Officers' Wives' Clubs, and Airman Advisory Council. In addition, individual volunteers over a certain age should be accepted. However, blanket acceptance is not encouraged. You have the responsibility to be selective.

Qualifications

RAPPORT. A staff member must be able to establish rapport, or else there will be little credibility established.

INTEREST. An interest in and dedication to the helping of individuals will be detected by the caller and will serve to build a trust relationship.

COMMUNICATOR. The ability to get involved with the caller and yet maintain distance, in order to see the problem from a new perspective, will facilitate problem solving.

MAINTAIN ANONYMITY. The basis of a telephone counseling service is anonymity to encourage openness on the part of the person who needs help. The staff member who is unable to understand or accept this stands a chance of destroying the service's credibility, base-wide.

PSYCHOLOGICALLY FIT. A stable person will be able to help persons with problems and thus build credibility for the service. Enlist the aid of the local mental health services to assist you in adequate testing and selecting of the most qualified persons.

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Training

To have an adequately-trained staff, specific areas must be covered. These include basic pharmacology, values clarification, youth-related issues, use of equipment, general counseling techniques, crisis intervention techniques, referral counseling procedures, rules and policies, desensitizing words, local drug-scene information, alternatives, and legal implications. Initial training is good and necessary; but, equally as important is follow-on training on a continuous basis to build on self-awareness and team-building. A training plan must be developed and adhered to in order to have an adequately-trained and capable staff. (Delworth, 1972; Gladstone, 1973; Lester, 1973; McGee, 1974)

Exercise VI

Complete the following exercise.

1. Identify resources for seeking volunteers for a telephone counseling staff.

2. What are some qualifications desired in a telephone counseling staff member?

3. What areas must be covered in order to build an adequately-trained staff?

HALLUCINOGEN CRISIS INTERVENTION

Trips

BAD BODY. These involve a feeling that the person is having body traumas. For example, a girl felt that her body had forgotten

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to breathe automatically and that if she did not concentrate on breathing, she would die. Others have felt that their hearts stopped or that their bones were falling out or flesh was falling off. (For some, this takes on a death and rebirth context with almost religious significance.)

BAD ENVIRONMENT. These imply feelings of threat or dislike of the environment in which the "tripper" finds him/herself. This includes environment based on delusions or hallucinations which are often discussed. For exampele, the cracks in the ceiling may take on the form of an extremely threatening or disgusting monster or, perhaps, the face of a disliked friend or relative. Spots on the wallpaper have been known to "launch a concerted attack" on a "tripper." But, less dramatic, there are environments which are just not enjoyable. A dirty room has been known to cause great discomfort for a girl who can't stand dirt. The same has been true of crowded rooms or rooms which have loud music or flashing lights, such as rock concerts.

BAD MIND. These usually constitute the most devastating effects. It is really hard to lose enough touch with reality to feel that one is dead and still thinking about it. But, the bad mind "trip" is really quite easy to create. Most common is the feeling that the "tripper" has gone insane; that he/she is hopelessly lost in an abyss of his/her mind which has no end and no exit. This can also take the form of feeling that a mother or father has rejected the "tripper" or that a boy/girl friend has really not been in love but rather just using the "tripper." In short, most of these bad mind "trips" seem to be the outward expression of a pre-existing but repressed psychological problem which the individual has been keeping (with greater or lesser success) locked up within him/herself.

Reactions

INSANITY. Certain bad reactions during the "trips" could possibly occur. A brief digression might be pertinent as to what a bad "trip" on drugs can be. Of course, there are really about as many different types of "bummers" as there are types of people. In general, it can be explained in terms of an inability on the part of the "tripper" to associate his/her present state of mind with a drug. This occurs in different ways. On occasion, an LSD user will actually forget that he/she has taken a pill and feel that he/she has gone insane. More often, the "tripper" will have a "loss of immediate short-term memory" or, as "trippers" put it, will be "spaced." In this mental state, time is so distorted

that they feel an extremely long period of time has passed, when, in fact, the period may have been minutes or even seconds. In this state, "trippers" can easily feel that the drug should have worn off and their present state is only attributable to their having gone insane.

ANXIETY. Most commonly, the reaction will be one of anxiety. This may include symptoms such as shaking, sweating, cold hands and feet, time distortion, and an overall feeling of discomfort. But, this is not to rule out bizarre and unusual effects. Cases where "trippers" felt they were being attacked by orange dots, where they felt they were dead or that their heart had stopped, and other strange phenomena have been seen.

PARANOIA. Manifested by feelings that the caller is in imminent danger, an extremely paranoid reaction can result. The feelings of guilt for using illegal drugs cause people and environment to appear threatening.

HALLUCINATIONS. Extreme distortion of sight and hearing are present. Seeing giant cockroaches or being attacked by big, orange dots have been reported.

DISTRUBING MEMORIES. Disturbing memories which have been suppressed sometimes come out, because of "knocked-out" defense mechanisms.

Techniques

BE SUPPORTIVE. A strong supportive therapy is just what it sounds like. You should, at all times, remain calm, be reassuring, and understanding, and, under no circumstances, should you be critical of the activities of the "tripper."

ESTABLISH REALITY. Providing a reality-base again is somewhat self-explanatory. As mentioned earlier, the biggest danger is that the person will not accept the fact that he/she is under the influence of a drug. During this phase of intervention, try to reassure the caller that his/her feelings are mainly due to the drug he/she has taken. In a sense, this helps the person recompensate by means of a temporary externalization which pulls him/her away from the notion that he/she has lost his/her mind. We repeatedly emphasize that once the drug effects have worn off, he/she will no longer feel the way he/she does. Statements, such as, "You are having a bad 'trip,' but it's going to pass," or, "It's because of the drug you took, and the bad feelings will end soon," are quite helpful. This point must be made clear and

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repeated until you are certain the message is getting through. (NOTE: Sometimes, it is impossible to make the "tripper" believe you. So be it. Don't fight, but do keep reminding the person that you think he/she is on a drug. This gives the person a stable reference point in you.) Because drugs often come in different dosages (accidently or intentionally), a person who is familiar with the effects of a drug might be confused. For example, today the drug STP usually has an effect which lasts about 12 to 24 hours. When it first came out, the dosage was so high that it lasted nearly 72 hours. Getting "better" drugs might increase the amount of time involved or the intensity of the feelings received.

REDUCE SENSORY OVERLOAD. The bad environment "trip" nearly suggests its solution in its name -- change of environments. Hallucinogens sometimes strip away an individual's ability to isolate specific things and concentrate on them. Talk to someone in a crowded room, and you will see that you can hear the other person clearly. But, listen to a tape recording of the same conversation, and it will be impossible to recognize. The reason is the human mind allows you to "filter out" the majority of the other "noises" and concentrate on one person. The tape recorder has no such "filter." A person on LSD or, for that matter, any hallucinogens can be like that tape recorder -- unable to screen out the tremendous number of inputs to his/her senses. This results in what we usually call "sensory overload." The user is bombarded by a myriad of inputs which confuse, frighten, and incapacitate him/her. Another form of environment bad "trip" comes from a specific item in the environment. This can be an individual, a certain couch or chair, the wallpaper, etc. In all of these environmental "trips," the "tripper" is best removed from the threatening and confusing environment into a more suitable one, one in which his/her focus of attention should be brought to a neutral object which can be appreciated. Taking a person outside in nice weather and showing him/her a flower is perhaps the oldest form of treatment of "trippers," and still one of the best.

COUNSELING. This is perhaps the most intriguing because the temptation to play "amateur psychiatrist" is great on the part of the person helping. In the bad mind "trip," the individual has made manifest a suppressed and repressed part of his/her personality. When the person "helping" the "tripper" starts to delve into his/her psyche, to push around his/her problems, the helping person, more often than not, makes the problem worse. Such manipulation of the human psyche is considered by some to be simply malpractice. Treatment here consists of getting the person "out of

his/her mind" -- totally engrossed in a body or environment "trip." The word totally is important. If not totally involved, it is easy to get back and start thinking. One caller was told, for example, to go to the zoo and run (don't walk) around shouting (not talking) to the animals! Total involvement is required. The person who says he/she wants to solve his/her problems should be told that he/she can solve them tomorrow -- get moving now.

DIVERT ATTENTION. Given a body "trip" which involves a death feeling, a tactic which is often used is to first reassure the person that when the pill wears off, he/she will be "reborn" or at least alive. Then, change the actual setting -- get the person outside, or into a different room. The person should be shown some interesting object. (Remember, it is much easier for something to be interesting to the "tripper" than to be interesting to you, such as a tree, a flower, a stone. All of these things can be amazingly interesting and enjoyable.) Of utmost importance, of course, is that the "tripper" be diverted from his/her body. This may not change his/her hallucinations (for example, that his/her veins are falling out); but, it will allow the person to spend most of his/her concentration on something which is more happy and relaxed, despite the fact that he/she continues to feel that the delusion exists.

TURNING THE BAD "TRIP" INTO A GOOD ONE. The nonuse of this phrase is obvious, for a number of reasons. First and foremost, it is too awkward to get out; but, more important, it says that what you will do is to help the person using the drug to enjoy him/herself. Many individuals feel that this is not only an amoral service, but that it is an immoral service. They believe that the "sinner" may be saved only through pain and suffering. This attitude in this setting is an extremely dangerous one which could result in long-term harm to the user. In short, persons who are not willing to help a drug user enjoy a "trip" will have trouble in a crisis service.

Exercise VII

Complete the following exercise.

1. What are three possible types of hallucinogen "trips," and some characteristics of each?

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2. What may cause feelings of paranoia when having a bad hallucinogen "trip"?

3. How can attempting a counseling situation affect a person on hallucinogens?

STIMULANT CRISIS INTERVENTION

Symptoms

A wide range of characteristics is possible, depending on the dose. Included are nervousness, restlessness, irritability, insomnia, talkativeness, paranoia, aggressiveness, violence, overconfidence, loss of appetite, malnutrition, mental depression, increased blood pressure, auditory hallucinations, delusions, blackouts, and tremors/convulsions.

Counseling Techniques

ASK: "What did you take?," "How much?," and "How long ago?" The remainder of your actions will probably be built around the answers to these questions.

LISTEN. Allow the person to talk about anything. This talking will allow a gradual trust-building, as well as reduce anxiety. If allowed to openly discuss any subject freely, the feelings of paranoia also might be reduced. The person who is up on a "trip" will generally have "all the right answers" and will not be likely to accept suggestions.

REALITY. It is important to keep the person in touch with reality while "up." When the "trip" is over, and there is a letdown, or depression, the "tripper" will be better prepared for this stage by being in touch with reality.

CONTROL. The conversation a counselor has with a person who is "up" will also help that person maintain control of self, once the "trip" is over, and help preclude possible feelings of suicide.

STIMULI. Extraneous stimuli should be avoided, when possible. These stimuli only increase the possibility of bizarre behavior, such as aggressiveness, delusions, power "trips," suicidal tendencies, etc. These include loud noises, flashing lights, or touching.

MEDICAL ASSISTANCE. Medical assistance will generally not be required unless an extreme threat to self and others around appears imminent. Do not recommend or give the person another drug.

Exercise VIII

Complete the following exercise.

1. What three questions should be asked of the person suspected of stimulant involvement?

2. Describe steps to take after asking these questions.

SEDATIVE-HYPNOTIC CRISIS INTERVENTION

Symptoms

Symptoms include drunkenness, slurred speech, muscle incoordination, impaired thought process, drowsiness, lethargy, depressed respirations, unconsciousness, coma, shock, or respiratory failure.

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Counseling Techniques

SEVERITY. If possible, determine severity of the problem by asking, "What did you take?," "How much?," and "When?" Base your actions on the answers to these questions.

AWAKE. Keep the person awake and conscious by walking or talking.

DRUG. Do not suggest the use of another drug, either when the person is awake or unconscious.

VOMITING. Do not induce vomiting. Even if the person is conscious, unconsciousness could occur and vomiting would only block air passage.

MEDICAL ASSISTANCE. Medical assistance should be suggested when the severity of the situation worsens. This would be unconsciousness, combined with decreased respiratory rate; also, in cases of withdrawal due to its severity (convulsions).

Exercise IX

Complete the following exercise.

1. What two things should a counselor not do when dealing with a person suspected of sedative-hypnotic drug involvement?

2. When should medical assistance be suggested?

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NARCOTIC-OPIATE CRISIS INTERVENTION

Symptoms

USE. Characteristics of use as opposed to withdrawal characteristics are drowsiness, vomiting, lethargy, stupor, pinpoint pupils, scratching or itching, needle marks, blood stains on clothing, constipation, and respiratory depression.

WITHDRAWAL. Characteristics include increased anxiety and irritability, watery eyes and runny nose, nausea, cramping, cold, clammy skin, and tremors.

Counseling Techniques

ARTIFICIAL RESPIRATION. Only as an interim measure until medical help is obtained, should artificial respiration be used. The depressant effects may progress to shock and coma.

BED REST. When experiencing withdrawal from the chronic use of narcotics, the uncomfortable, unpleasant experience resembles a bad case of the flu, but seldom warrants medical attention. Bed rest and lots of fluids can carry an individual through the five to seven days of withdrawal.

DRUGS. Do <u>not</u> recommend or suggest the use of any other drugs.

OBSERVING. Generally speaking, allow the symptoms to run their course, but maintain observation in order to detect severe changes which might require medical help, such as a rapid onset of respiratory depression/failure.

Exercise X

Complete the following exercise.

1. When should medical assistance be solicited for someone suspected of narcotic-opiate drug involvement?

2. What is one "don't" a counselor should be aware of concerning narcotic-opiate involvement?

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MULTIPLE DRUG CRISIS INTERVENTION

Techniques

REACTION. Drug interactions resulting from the simultaneous use of two or more different or alike drugs will produce effects different, in type or intensity, from those produced by each drug when used alone. (Drug interactions can antagonize, decrease, add to, or potentiate the intensity and/or completely change the type of a drug's effect.)

COUNSELING. The consequential effects of a drug interaction are difficult to predict, due to the many varied factors involved. Emphasis should be placed on observing vital functions — state of consciousness, heart and respiratory functions -- for detrimental effects. When a person becomes unconscious, experiences heartbeat disturbances, and/or respiratory depression, medical assistance should be summoned at once. As in any drug-related crisis, as long as an individual's condition can be stabilized, and he/she is not experiencing any harmful effects, you are working within your limits and need not refer for medical assistance.

Exercise XI

Complete the following exercise.

Describe techniques for multiple drug involvement counseling.

SUICIDE CRISIS INTERVENTION

Statistics

FACTS. Of the 250,000 suicide attempts per year in the United States, 25,000 succeed, or a number of people equal to the population of Helena, Montana. Women attempt suicide more than men, but men go through with it more successfully than women. Whites are twice as successful as blacks; singles twice as successful as marrieds; and college students twice as successful as non-college students. Among adolescents, suicide is the third highest cause of death. (Shneidman)

MYTHS. Myths still saturate the topic of suicide and often deter people from seeking the support that may, in fact, save their lives. For instance, consider the myth that a person commits suicide without warning. In fact, the suicide act is often carefully considered and communicated to other people in either covert or overt clues. Another myth is that those persons who talk about suicides never kill themselves. Talking is a cry for help, with clues and warnings. Eight out of ten who talk about suicide go through with it. A third myth states that talking about suicide to a depressed person causes suicide. Facts prove differently, however. Encouraging depressed individuals to talk about suicidal feelings can be beneficial. (Shneidman)

Warning Signs

Reasons vary from the most shallow to the deepest. Some persons find they no longer have a tie with the community or society, their relationship with parents has diminished, they are extremely lonely (especially around Christmas-time), they are afraid of failure, they have been rejected, or there is just a low self-esteem. A suicide call generally can be a call for help on a decision to live or die. It is a call from a person expressing helplessness or hopelessness, or, stated differently, a call from a person who feels unable to cope or feels that others are not responding to him/her. Every call, though, is a cry for help. Even the most ardent death wish is a cry to be saved. Verbal communication in a suicide call might reflect: "I no longer want to live."; "I want to die."; "I'm no longer interested in work or family."; or, "I won't be around tomorrow." Action communication might include the caller's indication of a purchase of a weapon, a collection of pills, giving away of possessions, or sudden changes to a will. All of these should be considered by the counselor in determining suicide potential.

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Goals

When handling the potential suicide, the counselor should establish a good relationship. This includes total, unconditional acceptance of the person as a person, a willingness to listen, and a willingness to help. The counselor must also maintain contact. Whether the potential suicide is on the telephone or in any other situation, maintaining verbal contact insures your knowledge of where the person is and keeps you informed of his/her actions. Obtaining information allows the counselor to do both of the aforementioned things. In addition, it allows for the development of a plan of action, based on the suicide potential.

Counseling Techniques

RIGHT DECISION. Let the person know that contacting your counseling service and asking for help was the right thing to do. This shows an interest in the person and helps to establish the relationship.

LISTEN. The person has contacted your service. Allow him/her to talk without interruption, if possible. With the person presenting the circumstances in words which he/she wants to say, this might find the person being heard for the first time without being editorialized, cut off, or interrupted. The way is set for action and trust.

REQUEST NAME. If possible, and at an appropriate time, attempt to get the name of the person. If on the telephone, request location.

SIGNIFICANT OTHERS. Additionally, in your conversation, solicit names and telephone numbers of significant other persons in the life of the person. It is important how you use those names so that a negative effect is not the result. For instance, if a close friend is a significant person, but the close friend is the cause of the attempted suicide, suggesting contact with this friend might cause a person to carry out the suicide.

PATIENCE. By the counselor being patient, hopeful, self-assured, and knowledgeable, the person with whom he/she is talking will be able to "get in touch" with his/her own feelings.

ACCEPTANCE. Total, unconditional acceptance of the person is essential. Moralizing or sermonizing on death at the moment is not unconditional acceptance, but rather telling the person how your value system is constructed. The person probably doesn't need to hear this.

ZERO IN. A part of the person wants to live. Find it, and build on it. It could be children, the spouse, or the fiance/fiancee. It could be the answer to solving the problem.

DIRECT PROBLEMS. There may be several small, indirect problems which are uppermost in the mind of the person calling. Behind those, however, might be the direct problem. Talk through those indirect problems to the direct ones.

CALM EMOTIONS. Help the person gain self-control and self-confidence before attempting to go too deep into the questioning.

HELP ORGANIZE. With emotions calmed and direct/indirect problems specified, help the person organize priorities of problems and sort through what may be too many details to the core of the threatening situation.

DETERMINE ALTERNATIVES. Encourage the person to identify the alternatives available for him/her. The person should identify as many of them as possible before the counselor begins. This will encourage ownership of alternative solutions. In addition, encourage the person to try the alternatives, even though "they will never work. I know. I tried (or thought about trying)."

DETERMINE POTENTIAL. As you are listening to the individual in crisis, and directing your questions to get to the answers, you will also subconsciously be developing a plan of action based on what you consider the potentiality of the person to act. Factors to consider, together with a "gut-level" feeling, include age, sex, plan of action, lethality, availability of means, specifics of plan, amount of stress, symptoms of depression, psychosis and agitation, resources, life style, communication aspects, reactions of significant others, and medical status. With this information, you can act as you feel appropriate in order to help the person who wants help. (Berg, 1970; Lester, 1971; Farad, 1975; Sheidman; Specter, 1973)

Exercise XII

Complete the following exercise.

1. What are some "action" communications to consider in a potential suicide situation?

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2. Identify three main goals of a counselor in a potential suicide situation.

3. Identify considerations to use in developing a plan of action.

RAPE CRISIS INTERVENTION

Needs

PHYSICIAN/MEDICAL. The rape victim's state of health is of primary concern after the incident. She needs reassuring of her physical condition, as well as a prescription for an anti-pregnancy medication and an anti-venereal disease medication. In many instances, the victim would come to the hospital first, hoping to get medical aid and confident that the police would be notified by the hospital personnel.

AUTHORITARIAN FIGURE. The victim of a rape seeks the police both for aid and assistance. The police were the "official" persons to turn to in such an emergency, being viewed in the traditional role of defending, supporting, and protecting the community against crime. The victim wanted the policeman to "do something" about the crime, such as getting the assailant or beginning the investigation.

LISTENER. The victim needs someone to talk to about what has happened in order to receive support and assistance about what to do next. Feelings and reactions need to be identified in a situation other than in a medical or official setting. The listener needs to be supportive and non-critical of the victim. Many victims go for days without talking about what has happened for fear of being condemned.

CONTROL/STABILITY. The rape victim needs to maintain or, in some cases, regain self-control. Some have experienced shock or extreme confusion and loss of control.

FOLLOW-ON SUPPORT. In some cases, medical and emotional follow-on care is a definite necessity. Psychological counseling might be an appropriate referral. Handling guilt feelings or family problems which might occur as a result of other members of the family being unable to accept the victim could require referral to an appropriate family therapist.

Conditions

Feelings of a rape vicitim could include guilt, a disrupted life style, long-term life style changes, anger, withholding emotions, pain, nausea, fear, and a mood swing from humiliation to degradation to revenge.

Counseling Techniques

REASSURE. In the time of severe crisis for the person, a calm, reassuring counselor will help the person get through the medical and official reporting part of the after-crisis phase.

MEDICAL NEED. Determine the medical needs of the person as soon as possible. If there has been no attempt to go to a hospital, encourage the person to go as soon as possible, and explain the reasoning behind her doing this.

REPORT CRIME. If the person has not reported the act to the police, encourage her to do so as soon as possible. This may prevent other persons from becoming victims of this criminal act, and doesn't obligate a person to prosecute.

SIGNIFICANT OTHER. Encourage the person to call a significant other person and relate the incident, in order to release some of the feelings and thoughts to someone closer.

REFERRAL. This would generally occur if the victim didn't know which way to turn, and the situation had just recently occurred. Referral would then be to a hospital and/or the police. Follow-on counseling would establish a different need for referral counseling, as it would allow more personal, individual contact with a trained counselor.

LABEL. Do not label the person as a "rape victim." This only adds to the uncomfortable feelings already being experienced.

FALSE REASSURANCE. Do not offer things that are impossible to accomplish. "Everything is going to work out just fine." might prove to be a generally calming statement, but being any more specific might be making promises you cannot follow through on.

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LISTEN. Do not fail to allow the victim to talk through in words chosen by the victim, not by you. Allow the feelings and emotions to flow as you are listening.

TERMS. Use of the word "rape" causes the victim to relive an extremely uncomfortable situation. Use of terms such as "occurrence" or "situation" is easier for the victim to hear and acknowledge. (Burgess, 1974; Guerra, 1975)

Exercise XIII

Complete the following exercise.

1. What are the five major needs of a rape victim?

2. What should a counselor not do when counseling a rape victim?

PROBLEM PREGNANCY CRISIS INTERVENTION

Techniques

When discussing with the person concerning a problem pregnancy, before decisions can be made, basic information is necessary. For instance, determining the age of the female, and approximately how many weeks pregnant she is. The individual's wishes are also important here, because the decision made is going to have to be hers. She needs an opportunity to express her anxieties and feelings, and an opportunity to discuss the alternatives and all of the legal and moral aspects of each choice. Her choices are abortion, adoption of the child, keeping the child and staying unmarried, or getting married and keeping the child. Society's influence on each of these decisions should be considered; but, the decision still must be hers. She is the person who has to live with the decision. In-depth counseling is available at such agencies as

free clinics, adoption agencies, medical services, churches, regional Planned Parenthood, family services centers, or homes for giving birth.

Exercise XIV

Complete the following exercise.

1. What are possible alternatives to consider for the pregnant woman?

2. What advantage is there in using an adoption agency?

HOMOSEXUAL CRISIS INTERVENTION

Society

RELATIONSHIPS. The homosexual in today's society is facing considerable decisions in the life style that has been accepted. We are taught from the very beginning of growing up that we have a free choice, and we believe this as we continue to grow. However, as we grow, we learn more and more that "free choice" does not mean "without cost." The homosexual learns that to make a choice of a sexual partner of the same sex, to express interest and sexual activities and receive sexual gratification from the partner of choice, is not done without paying a price. The homosexual lives in three worlds — the heterosexual world, the homosexual world, and the world of self. Within each of these worlds there is a price, along with the challenges of attitudes, laws, penalties, and society in general that sometimes forgets that homosexuality is no longer recognized as a mental illness.

HETEROSEXUAL WORLD. The price in this world involved labels and laws which cause the homosexual to go underground. In the

military society, there is the fear of discharge if discovered. In the civilian society, the fears include friends and family not understanding, as well as loss of profession or professional status.

HOMOSEXUAL WORLD. This world finds the homosexual learning a new life style which includes relating to other homosexuals, adopting new roles and accepting a secret life style in gay bars, or in gay society still very much underground.

WORLD OF SELF. This world causes considerable problems for the homosexual as an acceptance of self and new life style must be done free of guilt and shame. The homsexual must learn to accept being rejected, and must learn how to deal with a new set of standards and crises which occur around these standards, including individual masculinity or femininity, the results of the aging process and how it leaves its impact, and being rejected by the immediate family with no apparent reason.

Counseling Techniques

LABELING. Do not label the person as gay or homosexual or "butch." It will only aid in making the development of rapport between the counselor and client much harder.

GUILT. Consider the fact that a person might be experiencing guilt feelings because of possessing homosexual tendencies. A male might be quite effeminant in his behavior or a female quite masculine, but neither may be homosexual.

CRISIS. Determine what the real crisis is to the person who asked you for help. Is it guilt feelings of being homosexual, or guilt feelings of thinking he/she might be homosexual, or problems which are surfacing due to being homosexual.

REFER. Referral agencies might be able to give more in-depth counseling, but this must be at an appropriate time. If done too early, it could possible add to feelings of rejection already being experienced. If the person is referred to a gay crisis line, and the person is <u>not</u> homosexual, there might be considerable feelings of uncomfortableness. Gay liberation groups or professional counselors are also appropriate referrals. (Leznoff, 1969; Page, 1971; Simon, 1969; Weinberg, 1974)

Exercise XV

Complete the following exercise.

1. What are some fears the homosexual might be experiencing?

2. When would referral <u>not</u> be appropriate for the counselor?

RUNAWAY AND CHILD ABUSE CRISIS INTERVENTION

Runaway

OBJECTIVES. When counseling a runaway on the situation, a positive solution to the problem is first and foremost positive in the eyes of the runaway and family, as the problem exists and relates to both of them. Legal barriers must be respected in terms of revealing information to authorities or harboring a juvenile fugitive. It is up to the counselor to know the legal limits within the state or city in order to effectively serve as a counseling service.

COUNSELING TECHNIQUES. Counseling with a runaway involves building trust and confidence with someone who might be having difficulty finding anyone to trust. Do not make promises you, as a counselor, cannot keep, simply in an attempt to build trust. This will backfire in most cases, and destroy the trust if you can't follow through on your promises. Gather enough information on which you can act, according to how the runaway wants to be helped. Information such as age, reason for running away, the situation which precipitated the running away, and the date of the running away will assist you in aiding the runaway and the parents. Alternatives should be discussed with the runaway as to what is available for now. Included would be to continue running; to go home on his/her own; to go home with a friend or relative or significant other; to intervene with parents; to go to a social welfare agency, family court, or a crisis center established for runaways; to go to a close friend for support; to merely call home to inform parents of state of health; or to call a National or local crisis runaway "hot

line" which, in turn, will contact parents with no questions asked of the runaway.

Child Abuse

THE ABUSED. If the person asking help from you is the abused child, primary concern should be the need for medical assistance before attempting any further counseling. The child, in many cases, will be confused and in need of a strong supportive person in whom he/she can place trust. If there is a close friend or relative of the child available who fits this description, encourage the child to call them. The other alternatives are referral to a child welfare center or to the police. In some states, it is against the law not to report known cases of child abuse to proper authorities. Child welfare centers will offer shelter and a place to stay for the child, and will also accomplish the necessary reporting.

FRIEND OR NEIGHBOR. If the person contacting you is a friend or neighbor asking for advice, in most cases, it will be via an anonymous telephone call. They must be informed of legal implications if they do not properly report any known cases of abuse, if appropriate. In addition, the welfare of the child should be considered; for instance, if some action is not taken at the time of a known or witnessed child abuse, and it continues unreported, what are the possibilities of the abuse continuing? Proper referral agencies would include police or child welfare agencies. They can still remain anonymous when reporting child abuse cases.

THE ABUSER. A more unusual call or plea for help might be from the abuser. He/she might be considering abuse but was able to regain control before acting. Now, the request is for immediate help on a problem that the person is very aware of. Another instance could be the abuser's feeling guilty for previous abusing and wanting help. In either case, an appropriate referral would be to a Parents Anonymous group found in most cities, or operating in conjunction with family service centers. These Parents Anonymous groups and family service centers offer family counseling, individual family member counseling, group counseling consisting of members of other families, some of whom are also child abusers, and financial management assistance (referred to as the Homemaker Program). All of these services allow the concerned parent to work on the problems he/she is aware of which are causing a threat to the family relationship. If these welfare agencies are not available, a mental health worker would be an appropriate referral agency. The person who is asking for help needs to be helped as

soon as possible. Every effort should be made to place the person in contact immediately with a helping agency.

Exercise XVI

Complete the following exercise.

1. What alternatives are available for the runaway?

2. What services are available in some communities to cover child abusers?

EMERGENCY MEDICAL CRISIS INTERVENTION

Intervention

An emergency usually involves a crisis which has developed where there is imminent danger to self or others. When a counselor is faced with a crisis situation such as this, it will generally require direct and aggressive intervention by the counselor, in order to determine what the real emergency is as soon as possible. This will enable the counselor to have an accurate understanding of the situation, in order to act accordingly.

Poison

If the call concerns poisons, insure the poison assumed to have been swallowed has been correctly identified before recommending an antidote. If necessary, use a back-up telephone, in order to call for emergency medical help.

Accidents

If you receive a call concerning an accident, get the location, the type of accident, and extent of injury. An emergency squad or

the police would be the appropriate referral choices to handle the situation.

Exercise XVII

Complete the following exercise.

1. What action is a counselor responsible for in an emergency situation?

2. What should a counselor be sure of before recommending an antidote for a poison?

INFORMATION/"RAP" SITUATIONS

General Information

The information or "rap" situation is just what the name indicates. The person wants information which could range from reactions of a particular type of drug, street-drug information, advice on school studies, to local rock concernts, or even what's playing at the local theaters. It is important for the credibility of the counseling service that each staff member be as knowledgeable as possible on up-to-date happenings. The person might take the information and begin to "rap," the hidden agenda being to check out the credibility, the knowledge, and the sincerity of the service. If this provides enough stable ground for the person, the real truth behind the contact could come through -- a real crisis situation to that person.

Techniques

By showing an interest in the person from the very beginning and responding to the initial request, and being honest in your

responses, you have paved the way for the person to follow up with his/her crisis. It might not occur at that same moment, or with that same telephone call, but with the trust established, chances are good that the person will "open up" if there really is a crisis. A warning for counselors is to not answer the question: "Should I take . . . (a particular drug)?" You can give information about what you know of the drug, but the person who must make the decision to take or not to take it is the other person, not the counselor. If an information or "rap" call is from someone who just wants to talk, and is talking for an extended period of time, terminate the call tactfully, if you think nothing is being gained either by you or the person. Such statements as: "Say, I've enjoyed talking with you, but I've got another call coming in! Could you call back later?"; or, "I think we've been talking for a long time, and someone else might need to make a call." might be useful in terminating the call without causing the person to experience bad feelings about the counseling center. If a real crisis exists, the person will either reveal it at that time, or will call back if enough trust is built.

Exercise XVIII

Complete the following exercise.

1. What could possibly be the hidden message behind an information or "rap" call?

2. What is a <u>primary</u> warning for a counselor when handling an information call?

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TELEPHONE COUNSELING SITUATIONS

Potential

The telephone counselor should be aware that as innocent or as mild as any of these calls may appear, any one of them could possibly turn into a crisis situation, if the caller is afforded the opportunity to "open up."

Techniques

WRONG-NUMBER CALLS. A telephone caller who replies somewhat unsure of him/herself and states something like: "Oh, I'm sorry, I was just . . .uh . . .trying to call another number!" might not be calling a wrong number. The sound of your voice, as a counselor, might frighten the caller. A suggestion would be to ask the person what number he/she was trying to reach, and could you be of assistance? Attempt to transmit an encouraging and caring attitude. This might calm the caller so that he/she might begin to talk and relate a problem.

SILENT CALLS. No sound on the other end of the line might mean several things. One, someone who wants to talk has called and doesn't know how to talk. Two, the caller might be injured, confused, or unable to talk. It is critical in the early stages of such a call that some method of communication be established, such as tapping once into the telephone if a question could be answered, "Yes," and tapping twice if the answer is, "No." Probing questions can be asked, and information received should be written down and fed back to the caller as information. The more information received, the more questions that can be asked. It is important to also determine if the caller has been injured. Attempt to get the caller to "open up" once a trust-level has been established.

OBSCENE CALLS. The caller might be using the call for his/her own sexual stimulation. For instance, a male caller might continue to call until a female counselor answers the telephone. The counselor should at no time discuss his/her physical make-up, but rather attempt to get to some underlying problems which the caller might be willing to discuss. Perhaps a referral agency would be the best answer for a call such as this. Much understanding and patience are required by the counselor. Up to a point where the counselor decides, no confronting should be attempted. But, if the language and the caller together seem to have no purposeful use for the crisis line, confront the caller with his/her language, express the need to keep the line open for other callers, and indicate that you are going to hang up. If the caller needs help, he/she will call back if the counselor's hunches are correct.

CHRONIC CALLS. Chronic callers frequently are not making any decisions on their own about any problems. If, through your filing system, you determine a person is calling frequently, or you recognize a caller's voice several times, attempt to determine what growth, if any, the caller is making and what benefit it is for him/her to continue calling. If the staff is not learning something from the caller, or really getting upset over constant calls, confrontation is probably the best answer, and a proper referral is in order.

"PUT-ON" CALLS. If some personnel in the barracks are getting "smashed" and decide to give people answering the crisis line a "hard time," counselors are not in a position to know what is happening or even to be judgmental about the situation. A counselor's objective is to treat each call as real and serious and, hopefully, to convince the practical joker that he/she is serious about his/her work.

PROXY CALLS. In many cases, these calls are used to maintain anonymity of the callers. A proxy caller could be a friend calling for someone, or disguising his/her voice and calling for him/herself. The counselor should attempt to eliminate the middle person and have the person with the problem make the call. The problems presented should still be handled in a normal manner; i.e., getting the caller to take ownership of his/her own problems. (Polak, 1975)

Exercise XIX

Complete the following exercise.

1. What approach should a counselor use when dealing with a wrong-number call?

2. What type of questions does a counselor ask the silent caller?

3. What decisions should be made concerning an obscene caller?

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SUMMARY

The major areas covered in crisis intervention included those potential crisis situations which could happen in any number of settings at any time of day. The crisis intervention goal attempts to get the person in the crisis to use the resources available within and around his/her person. Effective crisis intervention is conducted when the counselor is aware of his/her feelings, as well as the person in crisis, and is able to use these feelings in a positive, creative problem-solving approach.

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SOCIAL ACTIONS TRAINING BRANCH
Lackland Air Force Base, Texas

LP BB-III-2.2 (2)
1 August 1978

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CRISIS INTERVENTION/TELEPHONE COUNSELING PERFORMANCE TEST

STUDENT NAME _____ RANK _____ DATE _____

INSTRUCTOR _____ GROUP _____

☐ Practice ☐ Evaluation ☐ Remote ☐ Role-play Telephone

COUNSELOR BEHAVIOR	S	NI	U	NO	INSTRUCTOR'S COMMENTS
1. ANSWERING TELEPHONE/MEETING CLIENT					
a. Pleasant					
b. Reassuring to client					
c. Speaks clear to client					
d. Encourages client to follow-on with the call					
2. IDENTIFICATION TECHNIQUES (Phone Only)					
a. Stresses anonymity					
b. Use of identification number rather than name					
c. Use of synonym for own name					
d. Does not reveal location of crisis center					
3. LISTENING TECHNIQUES					
a. Listens well					
b. Interjects to clarify comments					
c. Re-emphasizes specific points					
d. Encourages client through listening					
4. REFERRAL COUNSELING TECHNIQUES					
a. Determines if client is currently under care					
b. Does not make Multiple referrals					

S - SATISFACTORY
NI - NEEDS IMPROVEMENT
U - UNSATISFACTORY
NO - NOT OBSERVED

DESIGNED FOR ATC COURSE USE
DO NOT USE ON THE JOB

Attachment 2

1291 CRISIS INTERVENTION/TELEPHONE COUNSELING PERFORMANCE TEST

COUNSELOR BEHAVIOR	S	NI	U	NO	INSTRUCTOR'S COMMENTS
c. Insures client has correct referral information					
d. Encourages client to make own calls to referred agency					
e. Handles phone patch with professional agency (phone only)					
5. USE OF EQUIPMENT					
a. Telephone					
b. Forms					
c. Referral reference file					
6. THROUGHOUT COUNSELING					
a. Treat all clients/calls as real					
b. Establishes rapport					
c. Continues rapport					
d. Is Nonjudgemental					
e. Is Nonmoralizing					
f. Does not interpret client inappropriately					
g. Reassures client					
h. Appears real and sincere					
i. Does not react negatively to obscenities					
j. Is knowledgeable of local scene					
k. Unconditional regard for client					
l. Maintains credibility of counseling service					

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SCORING INSTRUCTIONS: A "Satisfactory" will be given if there are no "unsatisfactory" nor more than a total of five (5) "needs improvements".

OVERALL RATING: S U

Student Acknowledgement

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PLAN OF INSTRUCTION/LESSON PLAN PART I

NAME OF INSTRUCTOR	COURSE TITLE
	Drug and Alcohol Abuse Control
BLOCK NUMBER	**BLOCK TITLE**
IV	Program Management

COURSE CONTENT

1. Base Drug/Alcohol Program Management

RESPONSIBILITIES

a. Identify the management responsibilities of the senior installation commander and the social actions office in the drug/alcohol abuse control program.

b. Identify responsibilities and procedures for assisting the commander in the administration of the drug/alcohol abuse control committee.

c. Identify the functions of social actions personnel serving as members of drug/alcohol rehabilitation committees.

d. Identify procedures to maintain drug/alcohol abuse policy files.

PRIVACY ACT AND CASE FILES

e. Identify facts and procedures required to establish, classify/categorize, secure, and control drug/alcohol abuse case file disposition.

f. Identify the essential items to be documented in conjunction with social evaluations, intake interviews, ongoing counselings, and the writing of summaries of rehabilitation treatment.

DRUG REHABILITATION PROGRAM

g. Identify recommended procedures to coordinate drug rehabilitation program activities and formulate drug rehabilitation regimens.

ALCOHOL REHABILITATION PROGRAM

h. Identify recommended procedures to coordinate alcohol rehabilitation program activities and formulate alcohol rehabilitation regimens.

SUPERVISOR APPROVAL OF LESSON PLAN (PART II)

SIGNATURE AND DATE	SIGNATURE AND DATE

PLAN OF INSTRUCTION NUMBER	DATE	PAGE NO.
L3ALR73430B/L30LR7361B/L30ZR7364B	30 May 1978	35

ATC FORM OCT 75 133 PREVIOUS EDITION IS OBSOLETE

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REHABILITATION REGIMENS

i. Identify methods of formulating rehabilitation regimens, monitoring rehabilitee status, evaluating rehabilitee progress, and the regimen-planning functions of rehabilitation committees.

URINALYSIS PROGRAM

j. Identify methods used in the drug abuser identification and classification process, and social actions coordination responsibilities related to the urinalysis testing program.

PROGRAM EVALUATION

k. Identify methods and procedures employed to evaluate drug/alcohol education programs, and other social actions programs.

DRUG ANALYSIS

l. Identify procedures used to determine whether and to what extent drugs or alcohol are being used by an individual.

PERSONNEL DISPOSITIONS AND DATA SYSTEMS

m. Identify the appropriate drug/alcohol abuser disposition requirements with respect to Air Force Quality Force personnel actions.

n. Identify management resources and procedures which assist in the administration and coordination of the drug/alcohol rehabilitation and education programs.

REPORTS

o. Identify correct procedures for preparing required drug/alcohol abuse control reports. STS: 5b Maas: W

p. Given sample case file documents, properly separate the documents onto administrative or counseling information, and assemble them into a drug or alcohol abuse case file with 100% accuracy.

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q. Using an assembled case file, complete a rehabilitation summary of treatment in accordance with the criteria listed on the Rehabilitation Summary Performance Test.

r. After participating in a role-playing counseling exercise, document the session as an intake interview of a drug or alcohol abuser in accordance with the criteria listed on the Intake Interview Documentation Performance Test.

SUPPORT MATERIALS AND GUIDANCE

Audio-Visual Aids
35mm Slides, Base Drug/Alcohol Program Management
Videotape, AFIC Social Actions Program Management

Training Methods
Lecture
Group Process

Instructional Guidance
Explain how to coordinate and administer the drug and alcohol abuse control program by discussing the following subjects: Responsibilities of the senior installation commander and social actions office, the privacy act and drug/alcohol abuse control case files, administrative requirements of the drug rehabilitation program, requirements and recommended procedures for conducting the alcohol rehabilitation program, formulation and implementation of rehabilitation regimens, program evaluation, urinalysis program, drug analysis, personnel dispositions, data systems, and drug/alcohol reports. Conduct student performance practicums in case file establishment and documentation, and in conducting and documenting intake interviews.

*NOTE: Hq USAF/DPXHSD presentation on latest field development occurs in later part of unit and is reflected in hours for administration practicum.

3ALR73430B/30LR7361B/30ZR73 4B-IV/1.1 BASE DRUG/ALCOHOL PROGRAM MANAGEMENT (Responsibilities)

PART II - TEACHING GUIDE

INTRODUCTION (5 Minutes)

ATTENTION:

1. Have you ever been called by the Senior installation Commander and told to report to his office at a certain time. Upon reporting, the first question the Commander ask is, "What is my responsibilities in relationship to the drug and alcohol programs".

Your response would be what?

a. I don't know.

b. I'll have to look it up.

c. AFR. 30-2 states your responsibilities are...

2. The next question the Commander may ask is "How are we going to get the DAACC functioning better".

Your response would be what?

a. I am not sure.

b. I'll have to study it.

c. There are several ways to improve our DAACC...

MOTIVATION:

1. You will not only need to know the Commanders' responsibilities, but also Social Actions responsibilities, so you are always prepared to assist or brief the Senior installation Commander on all aspect of the drug/alcohol abuse program.

2. In order for Social Actions to be functionable and for all drug/alcohol programs to function effectively, social actions personnel must know their responsibilities.

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OVERVIEW

1. Cover the lesson objectives with the class.

2. This presentation will consider how to implement:

a. The Senior Installation Commander's responsibilities.

b. Social Actions' responsibilities in the Drug/Alcohol Abuse Control Program.

TRANSITION

In order for the drug/alcohol abuse program to work, everyone must thoroughly understand their responsibilities. The first area of responsibility we will cover will be the Senior Installation Commander's responsibilities and how to implement them.

BODY (50 Minutes)

PRESENTATION

1a. CRITERION OBJECTIVE: Identify management responsibilities of the Senior Installation Commander in the drug/alcohol abuse control program.

1. Identify the responsibility to establish the drug/alcohol abuse control committee (DAACC); to coordinate and monitor the activities of the individual organizations and staff agencies which have functional responsibilities in the program.

a. The chairperson of the DAACC will be designated by the Senior Installation Commander.

b. The DAACC functions as a board of advisors to the Senior Installation Commander and insures Drug/Alcohol Abuse Control Program policies and procedures are implemented.

c. The committee will meet at the call of the chairperson, but not less than once a quarter.

d. Directors of coordinating agencies are members.

e. The Senior Installation Commander approves the DAACC meeting minutes.

2. Identify the responsibility to establish a telephone counseling service on an "as required" basis.

a. DAACC makes recommendations as to whether or not the base will have a telephone counseling service based on an assessment of need for such service, and the availability of base and community services to meet that need.

b. Criteria used to determine needs are indications of high drug/alcohol abuse which may be indicated by:

(1) Excessive law enforcement actions.

(2) Urine test results.

(3) Drug overdose reports, etc., and limited local community capability of meeting base population needs.

c. The Senior Installation Commander provides appropriate facilities and telephone equipment.

3. Identify the responsibility to have liaison with community officials.

a. Community actions councils (AFM 190-9. Information Policies and Procedures). Identify common community/civilian interests, support common efforts of mutual concern, and obtain participation by base and community leaders in solving problems of mutual concern. The organization varies according to the installation and the community. AFM 190-9 provides some examples. Examples of what to discuss in relation to drug/alcohol include:

(1) Local school drug/alcohol problems.

(2) Local sources/countermeasures for drugs.

(3) Community-wide drug/alcohol speakers and educational programs.

b. Off-limits action (AFR 125-11, Armed Forces Disciplinary Control Boards and Off Installation Military Enforcement) should be taken when all other efforts to resolve an off-base problem, such as reputed sale of drugs in a particular establishment.

(1) Complaint is made to the installation commander, who inform the local Armed Forces disciplinary control board.

(a) The board members are the installation commanders in the area, with an additional representative from each installation.

(b) The local board meets and acts on individual cases.

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(2) The commander imposes temporary off-limits action, which is valid for ten days.

(3) The board informs the establishment of the complaints and allegations.

(a) A reasonable time is offered to correct the problems.

(b) The opportunity is offered to respond to the allegations.

(4) At the end of the time-period specified, the local board forwards its findings and recommendations to the originating commander.

(5) The commander meets with the installation committee and, if no objections are filed within ten days, the recommendations are automatically put into effect.

(6) Overseas commanders need to inform the appropriate local authorities of all "off-limits" actions and attempt to formulate coordinated law enforcement procedures.

c. Community drug/alcohol abuse resources are utilized, if necessary, and if compatible with the Air Force program. For example: Alcoholics Anonymous, Alanon, drug education, and rehabilitation centers, etc.

4. Identify the responsibilities of the commander to refer incidents of drug abuse to the Office of Special Investigations (AFOSI) (AFR 12-21).

a. Incidents do not automatically require investigation: a commander must request an investigation to be initiated.

b. When a drug incident occurs the commander must decide whether to initiate an investigation. If the commander choses to initiate an investigation he/she does so by forwarding a letter requesting one to OSI.

c. Investigations are normally not conducted on drug abusers identified through the Limited Privileged Communication Program (LPCP), since it is counterproductive to the nature of the program.

5. Discuss the review of the status of personnel involved in Alcohol/Drug Abuse incidents and the insure appropriate disposition action is taken.

a. Insures the cooperation of unit commanders and staff agencies.

b. The Senior Installation Commander determines disposition of members, when appropriate based on recommendations of the rehabilitation committee.

(1) In cases of discharge when the Senior installation Commander is the discharge authority.

(2) When there are disputes between unit Commanders and staff agencies concerning the disposition of rehabilitees.

6. Identify the Senior installation Commander's responsibilities to insure development, implementation and conduct education programs for military personnel, DAF civilians and dependents. (see fig. 4-7). Social Actions should encourage the Senior Installation Commander to feel like it his/her education program by having the Senior installation Commander:

a. Review Drug/Alcohol education lesson plans.

b. Review critiques on a random basis.

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c. Endorse the education programs

at staff meetings and other public gatherings.

d. Open classes personally or sent a Senior staff representative to add command emphasis.

e. Monior no show rates and whether the personnel training goals are being met.

7. Identify requirement to provide drug abuse control program support to tenant units and geographically separated units (GSU) IAW AFR 11-4.

a. Senior installation Commander is responsibile for providing drug/alcohol control program support to all tenant units.

(1) Drug/alcohol awareness seminar for Commanders, First Seargents and supervisors.

(2) Substance abuse education seminars.

(3) Drug/alcohol rehabilitation support.

b. Social Action should review host-tenant agreements. These agreements are formilized IAW AFR 11-4 and will establish the amount of support Social Actions will provide and under what conditions. These agreements can have an impact on manpower authorization and work load.

c. The senior installation commander is responsible for providing drug/alcohol education to all personnel assigned to geographically separated units serviced by the installations consolidated Base Personnel Office (CBPO).

(1) Commanders of GSUs will appoint an officer or NCO to monitor, coordinate, and conduct drug/alcohol awareness seminars.

(2) The use of USAF standard drug/alcohol education packages is mandatory when conducting these GSU seminars.

(a) Drug/alcohol awareness seminars for Commanders, First Sergeants and Supervisors.

(b) Substance abuse education seminars.

(3) Whenever possible, the officer or NCO appointed to conduct drug/alcohol education should receive OJT at the host support base.

APPLICATION/EVALUATION

1. What are the management responsibilities of the commander in the drug/alcohol abuse control program?

2. What is the key or an effective DAACC?

3. What is a temporary "off-limits" action and how long is it effective?

4. What persons are members on the Drug or Alcohol Rehabilitation Committee?

5. How can meaningful program data be secured from Security Police?

PRESENTATION

1b. CRITERION OBJECTIVE: Identify management responsibilities of the

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Social Actions office in the drug/alcohol abuse control program.

1. Identify the responsibility to administer and conduct the Air Force program of drug/alcohol abuse control.

a. Establish effective working relationship with staff agencies to ensure cooperation.

b. Establish rapport with unit commanders, First Sergeants and supervisors.

c. Monitor the flow of communication, progress of the rehabilitees through the various phases, the time frame of each program stages.

d. Develop local policy and guidelines concerning the effective management of the drug/alcohol abuse programs.

e. Advise the Senior Installation Commander on all aspects of the drug/alchol abuse program.

f. Initiate community liaison to coordinate policies and goals of the Air Force drug/alcohol abuse program with community agencies, and to obtain community support.

(1) Establish rapport with local law enforcement and court system.

(2) Identify community resources to be used as referral services.

2. Identify the responsibility to identify and organize on- and off-base resources to provide effective prevention, education, identification, treatment, and rehabilitation programs.

a. Prevention. Prevention of drug/alcohol abuse is accomplished by education and law enforcement. Let's first talk about law enforcement as a prevention tool.

(1) Law enforcement.

(a) Effective law enforcement can be used to reduce drug/alcohol abuse in the following ways:

1 If you reduce the supply/availability, generally you will reduce the amount of abuse; however, this method is not entirely effective.

2 If you increase the amount of DUI (Driving under the influence), generally you will decrease the incidents of DUI, and you will identify more problem drinkers earlier.

3. If you publicize drug/alcohol abuse information gained from law enforcement, you may reduce the number of incidents.

(b) Social actions does not have the responsibility for law enforcement; however, as overall drug/alcohol program managers, social actions, through the DAACC, should insure that the Senior Installation Commander's program is working effective.

(c) Ways to encourage your SP and OSI to develop effective on- and off-base drug/alcohol abuse/efforts is to have them indicate what they are doing in these areas to the DAACC and Senior Installation Commander. If they report on what they are doing, and the effect of what they are doing, chances are, you'll see an increase in their effectiveness.

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Social Action may suggest the following action through the DAACC:

(1) Using breathalizers, both portable and in clinic as a way of prevention of alcohol abuse.

(2) Barrack inspection for countrabands. (check with legal).

(3) Train law enforcement personnel in detecting drunk driving violators by observing unusual abnormal, or illegal driver behavior.

(4) Special patrols during periods when driving while under the influence violations must frequently occur to curb incidents.

(d) Another important aspect of on- and off-base law enforcement efforts is the statistics/data/information they can give you about the type of drugs abused, the type of incidents occurring, new street drugs on the local market that are particularly harmful, the general incidents of related crimes likes theft, areas where drugs are sold, etc.

(2) Preventive education.

(a) Education can prevent drug/alcohol abuse.

1 The AD Little study found that education prevented the use of at least some drugs (the choice of drug); and encourages some drug abusers to stop using illicit drugs.

2 Education which centers around personal growth, values clarification, and selection of viable alternatives may have an even greater prevention effect. However, the effect of this type of approach is yet unknown.

3 We will deal with methods of identifying and organizing on- and off-base education under the next topic.

b. Education. Conducting a top notch drug/alcohol education program involves the following efforts: Newcomer's orientation, substance abuse/commander/supervisor training, alcohol awareness seminars, speakers bureau, guest speakers, publicity/media coverage, and pamphlet, audio visual aids, and commander's calls. Let's first cover the newcomer's orientation.

(1) Newcomer's Briefing. Close coordination with the information officer is required to insure that social actions program information is included in the briefing. The social actions presentations should be brief and dynamic. Suggested topics for the briefing may include but are not limited to:

(a) Introduction to social actions programs.

(b) Recruiting volunteers (when the audiance is new to the base and looking for means to become involved).

(c) Equal opportunity and treatment program.

(d) Local drug and alcohol program, problems in the local area, and resources available for assistance.

(e) Local drug and alcohol laws.

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NOTE: Frequently, the SJA, SG, and HC offices have representatives at the briefings. Coordination should be accomplished to insure briefings complement and reinforce program relationships.

(2) The substance abuse and commander/supervisor standardized education seminars are excellent ways to reach large segments of you base's population. Insure you put your best foot forward so that substance abuse will be prevented, those abusing drug/alcohol will seek treatment, and commanders/supervisors will identify/ and cooperate with rehabilitation.

(3) The alcohol awareness seminar is designed to assist those with a need to know more about alcohol abuse and alcoholism to understand themselves, the drug, alcohol, and others who are having trouble with alcohol. You should encourage the supervisors, commanders, family, and friends of problem drinkers/alcoholics to attend this seminar, as well as those having the problem or who may believe they have a problem.

(4) Speaker's Bureau:

(a) Base information office normally maintain a file of Air Force personnel, both military and civilian, who have expressed an interest in making official public appearances and speeches before local groups and military audiences. Through coordination with the base information officer, members of the social actions staff may be included in this file, thereby providing excellent opportunities to publicize the social actions program. All requests for speakers must be approved by the base information officer before any commitment is made.

(b) Requests for speakers may be made on short notice; therefore, it is necessary to prepare speeches, briefings, etc., well in advance. Such activities are an excellent method to provide cooperation between the information office and the social actions office.

(c) The interaction by those activities with local civic groups is invaluable in publicizing the military and civilian programs and in developing added program resources.

(5) Guest Speakers. In addition to you speaking at off-base organizations, select the most outstanding speakers from the local community to speak on base, and recruit nationally renound speakers through your MajCom or the National Council on Alcoholism.

(a) Local speakers may be recovered alcoholics or x-drug abusers; but care must be used in selecting these speakers as they may glamorize drug/alcohol abuse to the extent that they actually encourage abuse.

(b) Local speakers may be used to inform civilian commander's calls of local rehabilitation facilitities and AA chapters.

(c) National Council on Alcoholism speakers, and others procured through your MajCom may be used to dramatize specific portions of your program. They also can be used to kick off "alcohol awareness weeks" and other campaigns.

(6) Publicity/Medial Coverage. Social actions should keep drug/alcohol abuse information in the forefront of public information media.

(a) Media coverage is needed to counteract the tremendous amount of medial advertizing designed to glamorize drugs and alcohol, and encourage their excessive consumption.

(b) To insure effective medial coverage the drug/alcohol specialist should do the following:

1 Establish close laison between social actions and the base information office (IO).

2 Write newspaper articles concerning: Drug/alcohol abuse, successful rehabilitation, alternatives to drug/alcohol abuse; or gain DAACC tasking for different staff agencies to write some of these articles.

3 Work with IO to develop publicity campaigns designed to highlight drug/alcohol messages.

(c) Credible material, in the form of pamphlets, fact sheets, books, films, etc., is essential to an effective information program. These materials can be used in the direct instruction of interested personnel and trainees, or for inclusion in newspaper articles, preparation of commander's call material, and other internal information programs. The social actions staff must review these materials to insure that they are factual and appropriate for publications available to base personnel.

(7) Selected materials will be made available through the Publishing Distribution Office (PDO) by HQ USAF. Materials not purchased centrally, but which have been approved, may be purchased locally if funds are available. The USAF Social Actions Resource Center will assist in researching materials and providing purchase source on request. Direct communication with the resource center is authorized

either by mail or telephone. Address: USAF SAAS/Lackland/TTZSR Lackland AFB. 78236. Autovon: 473-3505/3783.

(8) Audiovisual Materials.

Audiovisual training materials for Social Actions training programs will be only those approved by HQ USAF/DPXHS following evaluation and recommendation by the social actions Training Directorate, DCS/Technical Training. (ATC/TTMZ). Audiovisual training materials will include all films, records, cassettes, videotapes, tape recordings, pamphlets, brochures, posters, and reference materials used in social actions training programs. Films can be used in the following situations:

(a) Commanders calls.

(b) Officers' and NCO wives clubs.

(c) Youth education programs.

(d) Chaplain film discussions.

(e) Unit visits - during alert time, etc.

(9) Commander's Calls. Squadron commanders are required to conduct commander's call each month. While certain information is required to be presented, the commander has the option to present other topics of interest to his unit. This is an excellent way to make concise presentations to special interest items or activities in the social actions program, with the coordination and participation of the

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commander. These presentations should be limited to 10-14 minutes duration to fit the format of the commander's call. Suggested topic may include:

(a) Local drug and alcohol laws and enforcement.

(b) Volunteer training activities.

(c) Telephone counseling service operations.

(d) Equal opportunity and treatment program (type and actions taken on complaints, rumor control, on- and off-base problems and solutions, and so forth).

(e) "Question and Answer" sessions on program activities are an excellent way to learn how well the programs are being understood by base and unit personnel, and to promote intergency efforts to resolve social problems.

c. Identification. Your responsibility to insure that on- and off-base resources are organized to identify drug/alcohol abusers can be accomplished in the following ways:

(1) Education

(a) Encourage self identification through education.

(b) Encourage commander/supervisor identification through the commander/supervisor seminar, and commander's calls.

(c) Encourage medical identification and chaplain referral through specially oriented education programs for these specialists.

(2) Defining local procedures for identification so that unit commanders and staff agencies know exactly what is expected when they encounter a drug/alcohol abuser. To define local procedures you should:

(a) Publish general policy guidance in command letters.

(b) Follow-up this information by establishing local regulations which specify local responsibilities.

1 New regulations.

2 Local supplements to command and AF regs.

(3) Develop rapport and standard procedures with medical personnel for referral of drug/alcohol abusers identified through urinalysis or incident to medical care.

(4) Insure that the security police are referring incidents of alcohol abuse to you IAW AFR 125-14, and that you review the blotter for incidents of drug abuse. NOTE: Drug investigations to unit commanders, Commanders, however, should inform you concerning these events.

d. Treatment and rehabilitation. Social actions should identify and organize resources on- and off-base which can help in the treatment and rehabilitation process.

(1) On-Base Resources:

(a) Hospital/dispensory should have the capability for:

1 Emergency care/ crisis intervention involving drug overdose, psychiatric complications; or have plans on where they can secure this help when needed.

2 Detoxification, or know the nearest installation or hospical where it is offered.

(b) Social actions should have formalized agreements with mental health and the chaplain concerning referral of clients needing therapy and marriage counseling.

(c) Social actions should publish a referral resource guide listing all base resources, and have working relations with these agencies so that clients can be referred to them for legal, financial, and other types of counseling.

(d) Volunteers can be solicited from both on- and off-base. These volunteers can help with education, counseling, and involving clients in viable alternatives.

(2) Off-base Resources: Since most DAF civilians and many dependents need to receive treatment and rehabilitation off base, actualizing these resources, is very important.

(a) Local hospital/detoxivication centers - What do they offer? Cost? Insurance/CHAMPUS? etc.

(b) Local rehabilitation centers.

(c) Alcoholic Anonymous Alanon, etc.

(d) Mental health centers, etc.

(e) See Referrals SG.

(f) Agencies that promote alternatives to drug abuse: Recreation centers, religious groups, community service organization, etc.

(3) Centralized Rehabilitation :

(a) Rapport with the closest Alcohol Treatment Center is very important.

(b) You can increase rapport and smooth transition between the ATC and your follow-on support through;

1 Sending good case referrals and summaries of treatments.

2 Visiting and phoning the centers.

3 Encouraging unit commanders to visit the centers.

3. Identify the requirement to coordinate Drug/Alcohol activities with the medical, legal, and chaplain services; civilian personnel office (see AFR. 40-792), and other staff agencies relative to drug/alcohol control programs.

a. The Director of Base Medical Services (DBMS) is responsible for all medical aspects of the drug/alcohol abuse rehabilitation program including:

(1) Appointing a physician or mental health officer as a member of the Drug Alcohol Rehabilitation Committee to advise the Social Action Officer on the local rehabilitation program. He/she is a consultant to social actions and other agencies concerning the aspects of rehabilitation.

(2) Advise Commanders and supervisors on how to identify drug/alcohol abusers and how to refer them for medical evaluation and care.

(3) Provide medical care and evaluation of individuals with drug/alcohol problems.

(4) Provide detoxification as needed.

(5) Insure all physicians and medical personnel refer diagnosed cased of drug/alcohol abuse to social actions for rehabilitation, and followup support, following appropriate responsibility for the urinalysis testing program.

b. The Judge Advocate office should be consulted to provide overall advice, instruction, guidance an assistance on legal aspects of the drug/alcohol abuse control program.

(1) Staff training.

(2) Clear all implications for clients understanding.

(3) Advisor to the DAACC.

(4) A referral resource for clients.

c. Establish rapport with the chaplain services to gain support

and assistance in the areas of drug/alcohol abuse counseling and education.

(1) Chaplain have true privilege communication.

(a) May be used in drug cases; i.e. sale/transfer or criminal acts.

(b) May be used in alcohol cases; i.e. 4th/5th steps of AA, confession of misdeeds to a chaplain.

(c) May assist in family counseling.

(2) Chaplains often have new films that may be used in educational classes.

d. The Directorate of Civilian Personnel (DPC) administers and evaluates the drug/alcohol abuse control program and establish local requirements for civilians IAW AFR 40-792.

e. Rapport with each agency is the key to drug/alcohol abuse program support. The key agency chiefs should be the DAACC members.

4. Identify the responsibility to implement the standard USAF Drug/Alcohol Abuse Control Education Programs.

a. Minimum requirements are prescribed in AFR 30-2, figure 4-7.

b. All drug/alcohol educational guidelines, accurate in subject matter, and be presented in a professional manner.

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c. Standardized education package syllabuses, format, and methods

of presentation must be followed. All objectives must be met.

d. Personalize standardized packages to meet local needs, using local examples, statistics, and guest speakers.

e. Devise additional/special education programs as necessary to include the following for:

(1) medics,

(2) chaplains,

(3) Commander's Calls

(4) On- and Off-Base Organizations such as: NCO/Officers' wives clubs, Kwanis, Jaycees, Interagency Councils, etc.

f. Insure proper schedulining/ reporting by

(1) Obtaining personnel rosters from the CEPO/Personnel systems Manager/DPMQA.

(2) Schedule personnel through unit training monitors.

(3) Take attendance using the roster/cards.

(4) Return cards/rosters to the CEPO/DPMQA (or have prepared).

(5) Prepare/no-show rate graphs for use at staff meetings, etc., which compare unit attendance rates.

(6) These graphs may stimulate command interest and increase attendance rates.

(7) Verify attendance data using a printout roster to insure substance abuse training data stored in the Advanced Personnel Data System is correct/current. Provide CBPO/ DPMQA with new data or changes to the current data on reentry cards for correction of APDS.

(8) In case of reservists, attendance certificates, and letters are provided since APDS tracking is not available. Include the date, type and certifying signature.

(9) Report all substance abuse education IAW the Drug/Alcohol Abuse education and audiovisual aids available to overseas dependent education schools.

g. Social Actions will provide substance abuse education and audiovisual aids available to overseas dependent education schools.

5. Identify the responsibility to screen law enforcement actions and reports for drug/alcohol related incidents to help the unit commander identify members with drug/alcohol abuse problems. Local procedures should be worked out with:

a. Security police so that they can alert social actions to incidents involving drug/alcohol abuse. IAW AFR 125-14 and AFR 30-2.

b. Local procedures should be established to screen law enforcement actions and reports to help unit commanders identify members with drug/ alcohol problems.

c. Social Actions should review DD Form 1569, Incident/Complaint reports, and AF Rorm 53, Desk Sergeant Blotter when drug/alcohol or related incidents occur.

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d. Rapport with the security police is essential to timely notifi-

cation of drug/alcohol incidents.

e. Certain drug/alcohol incidents must be reported to high headquarters.

(1) Serious drug/alcohol incidents: A serious drug/alcohol incident is one which involves either of the following events:

a. Arrest of a group (10 or more personnel) involved in the sale or transfer of drugs.

b. Seizure of drugs with an estimated street value in excess of $10,000.

(2) Other drug/alcohol incidents: Incidents which do not meet the criteria for serious incidents but which, in the judgement of the installation commander, may result in adverse media coverage of significant mission impact should be reported without delay to MAJCOM/DPZ via priority message with an information copy to AF/DPX.

6. Identify the responsibility to assist the commander in the administration of the drug/alcohol abuse control committee and the drug/alcohol rehabilitation committee.

a. Explain that the drug/alcohol abuse control committee (DAACC) is the committee which coordinates all base drug/alcohol abuse control efforts. The following indicate responsibilities, and procedures a DAACC should follow.

(1) Review the senior installation commander's responsibilities regarding the DAACC.

(a) Establish the DAACC.

(b) Designate the chairperson (usually the Base Commander or Vice Commander, but suggest the senior installation commander if possible).

(2) State the chairperson's responsibilities:

(a) Establish the guidelines under which the DAACC functions. A charter which deliniates the DAACC's membership and membership responsibilities is often helpful.

(b) Use the committee to define specific local drug/alcohol problems, and inform the Commander's staff of these problems.

(c) Establish a plan/design to solve these drug/alcohol abuse problems. Include in the plan both milestones and goals in a management by objective format - a drug/alcohol "affirmative action plan."

(d) Establish local policy and procedure for base drug/alcohol abuse control.

(e) Assign responsibilities to each staff agency chief.

(f) Coordinate the efforts of all staff agencies having drug/alcohol abuse control responsibilities.

(g) Review the minutes and forward them to the senior installation commander for approval.

(3) State social actions' role in the DAACC.

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(a) Act as overall drug/alcohol abuse control program manager for the senior installation commander.

(b) Participate as a DAACC member/program expert/motivator.

(c) Function as a program advisor to the chairperson.

(e) Facilitate affective communication between DAACC members using good group facilitation techniques.

(f) Often, function as recorder to insure valid points are made in the minutes At least, monitor minutes to insure accuracy and emphasis of key points.

(4) State the staff agency chief/members' responsibilities.

(a) Attend the meeting themselves to represent their organization.

(b) Take responsibility and own their particular staff agency's portion of the drug/alcohol program.

(c) Report on their area of responsibility.

(d) Coordinate the actions necessary for accomplishment of their responsibilities.

(e) Participate actively in identification of drug/alcohol problems and formulation of objectives to prevent drug/alcohol abuse.

(5) State the procedures for conducting an effective DAACC.

(a) Insure each member has a copy of previous meeting minutes at least one week before current DAACC meeting to refresh their memory about open items, and help them formulate new agenda items.

(b) Insure all DAACC members are notified of date and time of meeting at least one week in advance; and request members to notify Social Action if they want any items added to the agenda.

(c) Facilities and equipment should be ready before meeting start.

1 Flip charts/ OH projects, etc.

2 Name tags

3 Insure enough chairs for a functional seating arrangement, SL personnel and recorder near the chairperson.

(6) Discuss common agenda items:

(a) Insure minutes are documented correctly, emphasizing key points.

(b) Cover recurring items first.

(c) Insure assigned open items are documented with starting date, milestone date, estimated completion date, and individual completing the item.

(d) Total DAACC efforts towards its charter should be recorded.

(7) Discuss common agenda items:

(a) Members should report on milestones in their area of responsibility that are D/A related at each meeting.

(b) Directors should report on innovative programs they have initiated over and above the required Social Actions programs.

(c) Encourage members to support any new programs or improve old ones; i.e., Alcohol safety, fast discharges, programs, unit sweep urinalysis, etc, and transmit and coordinate the procedures to the various staff agencies.

(d) Directors should outline and report on their agency's efforts in deglamorization and in destigmation of rehabilitees returning to their section.

(e) Entertain request for additional drug/aclohol training for commander, supervisor in addition to the standardized packages.

(f) The key to a successful DAACC is the ownership of particular aspects of the overall Drug/Alcohol Abuse Control Program by each staff agency director.

b. The drug/alcohol rehabilitation committee purpose is to determine an appropriate individual rehabilitation regimen, to evaluate each rehabilitee's progress in rehabilitation, and to recommend appropriate disposition to members unit commander.

(1) Membership is composed of each rehabilitee's unit commander, immediate supervisor, a physician or mental health officer or NCO (preferably the phase III evaluator), the drug officer of NCO, and other staff agency personnel involved in the rehabilitation of the member. Each rehabilitee's committe is likely to have different people on it. All committee members will participate fully in formulation of the appropriate disposition of a rehabilitee. The commander will be the chairman and approve/disapprove the committee's recommendations.

(2) For the initial rehabilitation committee evaluation of an individual each committee member should bring all the knowledge they have about the individual to the rehabilitation meeting to assist the commander in making the decision to rehabilitate or separate, what regimen will be established.

(a) Unit commander should bring their knowledge of information pertaining to unfavorable information files (UIFs), investigations judical information, special security file information, and other information, relating to the commander.

(b) Social Actions should have on hand information from the intake interview or social evaluation.

(c) The physician or mental health officer, or NCO should have on hand the medical evaluation, both physical and mental evaluation.

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(d) The immediate supervisor's input should be related to duty performance and behavior as

it apply to the individual's job.

(e) Other agencies should bring their input; i.e., Chaplain - family, counseling data, Judge Advocate - Legal implications.

(f) The committee determines if a individual is a candiate for future Air Force potential, Phase IV, Phase V, local/ central alcohol rehabilitation.

(g) The rehabilitation committed functions as an adviser to the unit commander.

(h) The committee's assessment and recommendation will be recorded and entered into the rehabilitatee's file, along with the unit commander's selection.

(3) The rehabilitation regimen is developed by:

a. Conducting the appropriate interviews by members of the rehabilitation committee.

b. Pooling the information available that each rehabilitation has.

c. Drawing up a systematic individualized plan which responds to the needs of the client.

(4) A well develop treatment regimen will assist the client and the rehabilitation committee to:

a. Provide direction to committee members when they interact with the client.

b. Give clients direction and allow them to evaluate their progress.

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c. Serves as an evaluative tool.

(5) Phase IV/Local Rehabilitation evaluation is designed to facilitate modification of behavior so that clients may adapt to Air Force standards. The decision to conform to Air Force standards is a voluntary one by the client.

(6) Drug/alcohol abuse control managers will coordinate and effect the rehabilitation regimen of clients throughout phase IV and local rehabilitation periods.

a. Make appropriate regimen appointments for clients.

b. Periodic evaluate clients progress through, individual and group counseling.

(7) The primary purpose of Phase V and Follow-on Support is to provide clients with an opportunity to demonstrate they can conform to Air Force standards.

a. The rehabilitation committee determines if clients need a supportive program of individual and group counseling, or if attend AA meeting is sufficient, etc.

b. The rehabilitation committee also determine if clients require only the knowledge that they are being observed and evaluated or more elaborate rehabilitation.

(8) Quarterly case evaluations by the rehabilitation committee is required so long as the person is in the rehabilitation program. However, significant

problems encountered by the client may require immediate consideration by the rehabilitation committee; i.e., regressions or recidivism, and revision of regimen. In this case a special meeting may need to be called.

(9) In the evaluation process, the rehabilitation committee must never lose sight of the fact that the client must voluntarily conform to Air Force standards of behavior and performance throughout the rehabilitation period. Feedback to the member and rehabilitation committee members should continue until the individual completes the drug/alcohol rehabilitation program.

7. Identify and promote programs that offer alternatives to drug/alcohol abuse.

a. Programs located on base are:

(1) Special services activities.

(2) Chapel programs.

(3) Educational services.

b. Programs located off base are:

(1) Local tours.

(2) YWCA and YMCA activities.

(3) Theater programs.

(4) Community organizations.

c. Social Actions should compile a current list and coordinate with the office of information to publicize the list.

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d. Alternatives should be available to persons of all backgrounds and sexes. This can be checked out by coordinating with the Equal Opportunity section.

8. Identify the responsibility to establish specific local goals for base level drug/alcohol abuse control program, to monitor progress toward those goals, and to inform the Senior Installation Commander on all aspect of drug/alcohol abuse program, including coordination of other staff agencies that support program operations and objectives.

a. Social Actions (with the help of individual DAACC members and the Senior Installation Commander), establishes local goals; i.e., reduction of DWI's, deglamorization of alcohol, and reduction of smuggling of drugs on bases in overseas areas, and present to the DAACC.

b. The DAACC chairman establishes OPR's and assists Social Actions in monitoring the milestones toward those goals.

c. Social Actions keeps the Senior installation Commander informed on the progress towards the establish goals through the DAACC minuts, graphics and charts at the Commander's staff meeting, briefings, and the quarterly Social Actions report.

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9. Identify the responsibility of social actions to inform unit commanders of persons referred to, or who voluntarily present themselves to social actions, when drug/alcohol abuse is involved.

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a. Social actions informs the unit commander when:

(1) An alcoholic is referred to social actions by competent medical authority for non-medical rehabilitation.

(2) A drug abuser voluntarily presents him/herself under the provisions of the Limited Privileged Communication Program.

(3) A Person presents him/herself under the provisions of the Concerned Drinker Program, and there is a medical diagnosis of alcoholism, or other persuasive evidence from any source that the individual has an alcohol problem.

(4) Any other source of information indicates drug/alcohol abuse, and these indications seem credible.

b. Social actions often receives information concerning drug/alcohol abuse from various sources. Social actions needs to keep unit commanders informed concerning the unit commander's people.

10 Identify the responsibility to establish cooperative information and education programs for drug/alcohol abuse with local civilian community service agencies.

a. The key to a seccessful exchange of information and education programs concerning drug/alcohol abuse is to get invited to participate in community activities such as:

(1) County mental health board.

(2) Drug/alcohol adviser board for county and city.

(3) Vetrans offices affairs.

(4) College that offer substance abuse courses.

(5) Local community drug/alcohol countermeasures program through law enforcement agencies.

(6) Community agency planning boards.

b. Social Actions should establish rapport by visiting community agencies to solicite their support for speakers in drug/alcohol awareness seminars or to use for inhouse training such as:

(1) A.A., detoxification centers, halfway houses, and drug abuse centers.

(2) Local school district, health education classes, libraries for new films, and T.V. educational stations for drug/alcohol abuse vidio tapes.

(3) Professional organizations; i.e., American Personnel and Guidance Association; American Psychology Associations, Drug/Alcohol Rehabilitation section; and International Transactional Analysis Associations.

c. Social Actions should give drug/alcohol education classes to various agencies in the community when requested; i.e., churches, schools, and community service clubs.

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CONCLUSION (5 Min)

SUMMARY

We have discussed the responsibilities of the Social Actions office and the Senior installation Commander and how to implement them.

REMOTIVATION

Understanding the information presented today will assist you in making Social Actions more effective. With the areas of responsibilities laid out clearly, each individual cannot make the excuse, "I don't know". The next time the Commander calls you, you can answer all questions with confidence and correctly.

ASSIGNMENT:

CLOSURE:

PART II - TEACHING GUIDE
INTRODUCTION (5 Minutes)

ATTENTION

1. Are you aware that you could be fined up to $5,000 for unauthorized disclosure of sensitive rehabilitation data?

2. When the Command IG suddenly arrives on base for their annual no notice inspection, you

a. Panic.

b. Feel there is no problem, then get written up.

c. Carefully recheck your previously prepared inspection checklist and feel confident when you finish.

MOTIVATION

1. Knowing your own responsibilities in regard to case files can make you confident when under the close scrutiny of a command IG, or under the penetrating questions of a rehabilitee.

2. Case file documentation must be stored under the provisions of the privacy act. Failure to comply is a violation of federal law and AF Regulation. You must know the proper procedures to protect your clients from unauthorized disclosures of information as well as yourself from fine.

3. Proper case file organization will enable you and your successor or substitute to find pertinent data about your client.

OVERVIEW

1. Cover the lesson objectives with the class.

2. Develop the lesson chronologically.

3. State that the following subjects will be addressed:

a. The purpose of the Privacy Act, and the publication requirements for all recordkeeping systems maintained by name or identifier.

b. The procedures for gathering personal information under the PA, the PA statement requirements of the Drug/Alcohol Abuse Control Program, along with the rights of the clients and penalties imposed for failure to observe the personal protections under the PA.

c. The safeguard requirements for access to, maintenance, transfer, and final disposition of drug/alcohol case files.

d. Two major sections of a case file, and the kind of information in each.

e. The essential items to be documented in conjunction with social evaluations, intake interviews, ongoing counselings, and the writing of summaries of rehabilitation treatment.

TRANSITION

First let us look at the purpose of the Privacy Act of 1974.

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BODY (1 Hour 45 Minutes)

PRESENTATION

1c. CRITERION OBJECTIVE: Identify the purpose of the Privacy Act (PA) and the publication requirement for all record-keeping systems maintained by name or individual identifier.

1. Discuss the purpose of the PA of 1974. The purpose of the PA is to safeguard an individual against an invasion of personal privacy from any misuse of information pertaining to that individual in the records of a Federal Agency.

2. Discuss the general publication requirement of the PA.

a. The PA requires publication in the Federal Register of all record systems maintained by an individual's name, or individual identifier and which contain items of information about the individual (paragraph 37, Air Force Regulation (AFR) 12-35).

b. HQ USAF/DPXH has already entered the drug and alcohol case files into the Federal Register.

PRESENTATION

1d. CRITERION OBJECTIVE: Identify the procedures for gathering personal information under the PA, the PA statements of the drug/alcohol abuse control program, the specific rights of clients, and the penalties imposed for failure to observe personal protections under the PA.

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1. Discuss the procedures for gathering personal information.

a. The PA requires that whenever a person is asked to provide "personal" information, individual must be advised of:

(1) The authority for collection of the information.

(2) The purpose and routing uses to be made of the information.

(3) Whether or not it is mandatory or voluntary to provide this information.

(4) The consequences of not providing the information (paragraph 30, AFR 12-35).

b. NOTE: These procedures apply whenever an individual is asked to provide his/her Social Security Account Number (SSAN).

2. Discuss the PA statements necessary when gathering personal information. For drug/alcohol abuse control personnel, PA statements must be provided to individuals under each of the following circumstances.

a. Drug/alcohol abuse case files. Each member on whom an active drug or alcohol abuse case file exists must be provided PA statement. An appropriate Air Force Standard Form is being developed and will be available during the first quarter of fiscal year 1977. In the interim, the statement quoted on an attachment to the study guide must be produced locally on either a blank AF Form 1607, Privacy Act Statement or on plain paper. A copy of this statement must be provided to every member currently in rehabilitation. In addition, every existing case file or treatment record must contain a PA statement.

(1) Before drug/alcohol abuse control personnel begin to gather personal data from a client to include in a case file a copy of the PA statement must be provided the client.

(2) Do not have the client sign the PA statement; however, drug/alcohol abuse control personnel should annotate one copy of the statement, indicating a copy was provided the client. Place the annotated copy of the statement in the case file.

b. AF Form 1611, Notification of Alcohol Abuse Information, and AF Form 1612, Notification of Drug Abuse Information. When either of these forms is initiated by a unit commander and sent to Social Actions, it becomes the responsibility of drug/alcohol abuse control personnel to insure the client receives a copy of AF Form 1611 (PA) or 1612 (PA) when they contain an individual's name, SSAN, and unit commander's signature. AF Forms 1611 (PA) and 1612 samples are attached to your study guide. An annotated copy of the AF Form 1611 (PA) or 1612 (PA), indicating a copy of the PA statement has been provided to the client should be attached to the AF Form 1611 or AF Form 1612 and filed within the case file.

c. Drug and alcohol education. If you require students in your base-level drug and alcohol education classes to furnish their SSAN when taking attendance, then you must advise them of the provisions of the PA. To insure this is properly accomplished, insert the PA statement, a copy of which you will find attached to your study guide in <u>all</u> lesson plans and read it to all attendees before you request students' SSANs. If an attendee requests a copy of the PA statement concerning drug and alcohol education, social actions personnel must provide same.

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3. Discuss the rights of the individual under the PA. The PA:

a. Permits clients access to their case files.

b. Permits factual corrections of records in a system of records (paragraph 17, AFR 12-35).

c. Restricts the use and dissemination of records without the individual's written request or consent. The restriction of access without written request is limited to Social Actions personnel; medical personnel; Veterans Administration (VA) treatment personnel when the member is transferred to a VA facility in active-duty status; commanders in the client's chain of command; and program evaluation personnel.

4. Discuss the liabilities for failure to comply with the PA.

a. Under the PA, Social Actions personnel are liable under criminal law, with penalties of up to $5,000 fine for:

(1) Failing to publish notice of a record system.

(2) Disclosure of an individuals case file to an unauthorized person.

(3) Obtaining access to an individual's case file under false pretenses.

b. Civil damage suits may also be filed against Social Actions personnel for violations of the PA.

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APPLICATION/EVALUATION

1. What must the individual be appraised of if required to give personal information?

2. What is the purpose of the PA?

3. Do individuals for whom a case file has been initiated have to sign the PA statement?

PRESENTATION

1e. CRITERION OBJECTIVE: Identify safeguard requirements for access to, maintenance, transfer, and final disposition of Drug/Alcohol Abuse Case Files.

1. Explain that the maintenance of Drug/Alcohol Abuse treatment records is prescribed by the following laws, codes, and regulations. These directives dictate the handling of case files which contain information on identity, diagnosis, prognosis, or treatment of rehabilitees.

a. Title 42 CFR, Part 2,

b. 5 USC 552,

c. The Privacy Act of 1974, PL 93-579,

d. AFR 12-31, AFR 12-35, and AFM 12-30.

2. The classification/categorization of Drug/Alcohol Abuse case files is IAW AFR 12-31, and as follows:

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a. Case files are highly sensitive files.

b. They are categorically designated, "For Official Use Only" (FOUO).

3. Discuss case files markings, storage, maintenance, and access.

a. Special markings for case file documentation or file folders are not required (para 10, AFR 12-31).

b. Adequate safeguards are provided by the Privacy Act 1974. "Title 42 CFR, Part 2, effective 1 August 1975 (Reference: Federal Register 40, July 1, 1975), and 5USC 552a, the Privacy Act of 1974, and Public Law 93-579 provide that special procedures be implemented for the handling of case files."

4. Safeguarding and maintaining FOUO material (AFR 12-31, AFR 12-35, and AFM 12-20).

a. Protect FOUO documentation--marked or unmarked--to the degree necessary to preclude unauthorized access. Apply common sense methods, observing the following:

b. During duty hours

(1) To prevent scrutiny, do not leave FOUO material unattended on desk.

(2) In the absence of internal building security, locked rooms normally provide adequate after-hour protection.

(3) Recommendation. If inadequate safeguards are provided for case files, FOUO documents, locked receptacles, such as file cabinets, or locked desks should be used.

NOTE: Where contractual internal security guards are used, FOUO material should always be in locked receptacles.

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5. Discuss access to drug or alcohol abuse case or treatment files.

a. Authorized access. Persons authorized to review, handle, or have access to drug or alcohol case of treatment files are:

(1) Personnel assigned to the Social Actions Office who are directly engaged in conducting or managing the rehabilitation program.

(2) Medical personnel directly engaged in the rehabilitation and treatment of a specific individual.

(3) Veterans Administration (VA) treatment personnel in the case of members transferred directly to the VA in active-duty status.

(4) Official members of individual rehabilitation committees.

(5) Commanders in the member's chain of command.

(6) Persons authorized to conduct program evaluations, with or without the consent of the individual concerned; e.g., Inspector General, Major Command, or Headquarters USAF personnel conducting staff visits.

(7) Individuals in rehabilitation have access to their own files, provided that, in the judgement of a physician, such access will not adversely affect the individual's physical or mental health.

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(8) Questions which involve personnel who do not fall under this category should be referred to the clarification.

(9) Persons authorized under Public Law 92-255.

b. Unauthorized access. Drug or alcohol case or treatment files will not be reviewed or handled by, or disclosed by any means of communication (oral, written, electronic, or mechanical, to any other person outside the Department of Defense accept as designated in paragraph a, above, and/or as provided under Public Law 93-579 (Privacy Act) without the written consent of the individual concerned.

c. Explain the use of drug and alcohol case of treatment file. While a military judge may, under 21USC 1175b(2)(C), have the power to order the production of drug or alcohol rehabilitation record, this will not normally be done. Such records are not normally to be released, except for the benefit of the individual concerned, and then only upon his/her written consent. The purpose of this policy is to protect the confidentiality of these records to the point where drug or alcohol abusers will not fear to be fully candid in revealing their situation, past offenses, etc.

6. Discuss <u>transfer</u> of records. Records are transferred when the client PCSes or transfers to the VA. There are several considerations when transferring records to other officers or installations. Failure to take the necessary precautions may jeopardize confidentiality of a case.

a. Records forwarded through the postal system should be placed in a double envelope.

(1) Address inside envelope to the office intended and mark it "For Official Use Only" (FOUO).

(2) Do not mark the outside envelope; however, obtain a local control number from administrative services. This procedure will help prevent sensitive case information from being opened by administrative personnel in error.

b. Case files should not be placed in distribution. Interoffice documents should be placed in double envelopes also. Mark the inside "For Official Use Only" and address to the person you want to see the documents. This envelop should be placed inside another envelope which is properly addressed, but not marked "FOUO".

c. Discuss forwarding records to the VA. Records forwarded to a VA hospital are also placed in a double envelope. The inside envelope must be marked "FOR THE EYES OF THE ATTENDING PHYSICIAN ONLY" and contain the name of the member.

d. Discuss forwarding records upon PCS. Reproduce a complete copy of treatment records. Original treatment records must be maintained by losing drug/alcohol abuse control office when rehabilitees PCS (Permanent Change of Station). Forward the reproduced case file to gaining organization to arrive no less than 2 weeks prior to members arrival.

e. Rehabilitees sent TDY for more than 30 days will have a "summary of treatment" letter forwarded to gaining SLD.

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f. Upon completion of TDY, servicing SLD will provide home SLD with summary of members progress.

7. Discuss the disposition of records, in accordance with AFR 12-50, Table 30-1, Military and Civilian Personnel, as follows:

a. Destroy drug files one year after completion of the program, separation, or PCS. Alcohol records are destroyed after six months.

b. Records are maintained if they are needed as background for case files, supporting separate action or other action under other directives. In this case, disposition is the same as for the document it supports. If the action involved is a court-martial, refer to the appropriate table in AFR 12-50.

c. Records used in administrative discharge proceedings (Normally a xeroxed copy) are destroyed one month after separation. This would not include the case file.

8. Destruction of case files involves measures which will prevent reassembly.

a. Unclassified material is considered destroyed when placed in trash receptacles, but FOR OFFICIAL USE ONLY material must be destroyed in such a manner so as to destroy the record content. Destruction methods include tearing into pieces, shredding, pulping, macerating, or burning, depending on the volume and available equipment and facilities. (Reference: AFM 12-50 (C13), paragraph 4-10, Authorized Methods of Disposal.)

b. Pulping, Shredding, etc., at a central destruction activity accomplishes actual destruction of classified material. This involves a destroying official and a witnessing official who:

(1) Insure complete destruction, and perform inventory.

(2) Ascertain the legibility of scraps.

(3) Mark the bag in which the documents are carried with the highest classification of the documents it contains.

(4) Deliver the bag to the central distruction activity which burns the shredded documents.

EVALUATION

1. What is the safeguard classification of Drug/Alcohol Abuse Control Case Files?

2. May interoffice case file documents be placed in distribution?

3. When are Drug Abuse Files destroyed? Alcohol Abuse Files?

4. How should case documents be destroyed?

PRESENTATION

1f. CRITERION OBJECTIVE: Identify the method, minimum documentation required, the two major sections of a case file, and the kind of information contained in each section.

1. Explain the method for entering data into the Drug/Alcohol Abuse Control case file. The data must be:

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a. Entered by a person who is authorized access to the case file,

b. Legible,

c. Accurate, relevant, timely and complete, to insure fairness to the individual, since these entries may be used in decisions affecting his or her rights, benefits, entitlements, or opportunities. Since the final determination of accuracy is necessarily judgmental, it is particularly critical that this judgment be made with an understanding of the intent of the Privacy Act of 1974.

d. Stated in behavioral terms. Insure that comments in the case or treatment record pertain to actual behavior, rather than conjecture about the individual's attitude or internal mental state. Do not use slang, social actions jargon, psychiatric labels, etc. Use plain, to the point, descriptions of the client's behavior or statements.

e. Signed by the interviewer, counselor, or person receiving and entering the information in the record.

f. Dated.

g. Does not include documentation other than the rehabilitee to whom the records pertain.

2. State the minimum case file documentation required by AFR 30-2 (Fig. 4-6):

a. AF Form 1611 or 1612, as applicable.

b. Rehabilitation committee minutes, or recommendation for the disposition of the rehabilitee.

c. Counseling record, where such record is authorized by major command social actions officer.

d. Record for rehabilitation urinalysis testing (for drug abuse).

e. Although the above data is the minimum required by AFR 30-2, additional data may be pertinent or even necessary to insure proper disposition and rehabilitation of the client.

3. Explain that case files are recommended to be separated into two major sections: The administrative and counseling sections. Division into two sections will enable easier accessibility to needed information during the course of rehabilitation.

a. The ADMINISTRATIVE SECTION of the case file consists of documentation related to a client's program status, and includes the following documents:

(1) Identification data such as:

(a) AF Form 1611 or 1612, with the appropriate AF Form 1611A or 1612A, Privacy Act Statement,

(b) LPCP/Concerned Drinker Program Agreements,

(c) AF Form 422, Physical Profile, containing a diagnosis, classification of abuse, or urinalysis result.

(d) AF Form 1659, Incident/Complaint Report, or

(e) Other documentation relevant to identification.

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(2) Documents reflecting demographic data, such as:

(a) Social evaluations,

(b) Intake interviews, etc.

(3) Records of administrative actions such as:

(a) AF Form 2095, reflecting current duty assignment and supervisor.

(b) Letters removing the client from HRP/PRP, Security access or clearance, or Flying status.

(c) Other forms or documentation concerning administrative actions.

(4) Memorandums for the record such as:

(a) Phase changes,

(b) Memos concerning the client's case or behavior/misbehavior.

(c) Memos concerning administrative/punitive action being taken against the client: Court Martial, Article 15, etc.

(d) Memos on failure of the client to meet scheduled appointments.

(e) Memos on any other administrative matter related to the client.

(5) Urinalysis reports. File individual urinalysis report letters by date of correspondence. If a urinalysis summary sheet is used, however, file it on top.

(6) AF Form 1607, Privacy Act Statement (for Drug/Alcohol Case Files), annotated with the date this statement was given to the client (file by date).

(7) Maintain the administrative section of the case file on the left side of the folder, and in chronological order with most recent on top. The urinalysis report summary, however, will be filed on top. Other documents will be filed by their date.

b. The COUNSELING SECTION contains documentation related to the substance of a client's counseling or rehabilitation. This side includes the following:

(1) The results of medical/psychiatric evaluations,

(2) Rehabilitation committee evaluations,

(3) Evaluations by commanders, supervisors, chaplains, and social actions evaluations/recommendations for disposition,

(4) Consults, referrals, return recommendations, and follow-up actions,

(5) Records of counseling,

(6) Summaries of Treatment,

(7) The counseling section is maintained on the right side of the folder, and is filed chronologically, with most recent on top. If a record of progress (progress summary) is used, it should be filed on top of the other documents.

c. Both sides of the case file should be affixed to the appropriate side of the file folder. The client's name (Last, First, MI), SSAN, and whether the person is a drug or alcohol rehabilitee should be indicated on the top portion of the file folder.

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APPLICATION/EVALUATION

1. Why is it necessary to use only behavior descriptions of the client's behavior in the case file?

2. When writing counseling notes in the case file, how should they be documented?

3. What is the minimum documentation required in case files by AFR 30-2?

4. State examples of the type of information contained in the administrative section of the case file. In the counseling portion?

5. Have the students report to their small groups to perform an application of this lesson.

6. Using the information in this lecture, and the guidance in SG-21 and WB-13, have the students reassemble the alcohol abuse case file for practice. When they complete this CTT assignment, the small group facilitator will indicate the correct order and answer questions concerning the procedure for case file organization.

7. The small group facilitator should then explain that the drug abuse case file must be assembled independently at home and turned in for a grade.

PRESENTATION

1g. CRITERION OBJECTIVE: Identify the essential items to be documented in conjunction with Social Evaluations, Intake Interviews, Ongoing Counselings, and writing Summaries of Rehabilitation Treatment.

1. Discuss two general rules to insure documentation is thorough.

a. Write down key words to avoid excessive writing during the counseling session and subsequent loss of attention to the client and eye contact.

b. Write complete counseling documentation immediately after the interview.

(1) Interview is fresh in the counselor's memory.

(2) Key words written down during the interview haven't lost their meaning.

2. Explain that if the rules are followed, documentation will be thorough, well written, easily understood and applicable to your clients rehabilitation and treatment.

3. Emphasize that well documented case files reflect the attitude, professionalism and sincerity of the office in which they originated.

4. Identify the essential elements for documentation of a Social Evaluation.

a. A Social Evaluation is conducted under the following circumstances:

(1) A positive urinalysis is identified and the following are true:

(a) A drug is not legally prescribed.

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(b) A physician is unable to clinically diagnose drug abuse.

(c) A member denies the use of illegal drugs.

(d) Social Actions conducts the social evaluation when directed by the unit commander.

(2) When an incident of Driving Under the Influence (DUI) occurs LAW AFR 125-14, and the social evaluation is directed by the unit commander.

(3) In the case of a concerned drinker who asks assistance in determining the extent of his/her alcohol problem.

b. The social evaluation is conducted by a person with experience in evaluating drug abuse. The unit commander may appoint:

(1) a Drug/Alcohol Specialist, or

(2) a psychologist,

(3) a sociologist, or

(4) a rehabilitation counselor.

c. The data gathered during the interview should include and be organized so that the demographic data is in outline format and the remainder of information in narrative format as follows:

(1) Demographic Data

(a) Provide appropriate information on the Privacy Act of 1974.

(b) Obtain full name, SSAN, age, sex, DOB, PAFSC, DAFSC, job title, length of service, length of time at present base, previous bases/units of assignment, current supervisors name and duty section.

(c) Identify all drug/alcohol incidents and means of identification.

(d) Review members personnel and medical records.

1. Personal records may be reviewed by the unit commander or first sergeant.

2. Medical records will be reviewed by a doctor upon the unit commanders request.

(2) History of Drug/Alcohol Abuse.

(a) Pattern of abuse: When abuse began, frequency of abuse, enviromental condition (with whom, when, where, what, how).

(b) Clients perception of their abuse and effects on behavior and feelings.

(c) Attitudes toward drugs of abuse.

(d) Abuse, at this point, may not be admitted by the client. Suggest you ask the commander for pertinent information from the client's unfavorable information file (UIF) and Special Security File.

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(3) Job Performance

(a) Satisfaction with present job.

(b) Satisfaction with supervisor.

(c) Satisfaction with co-workers.

(d) Description of work problems.

(e) History of job assignments; satisfactions with other jobs or work group.

(f) Career motivation.

(g) Performance reports.

(4) Judicial and nonjudicial occurrences

(a) Drug/alcohol related on nonrelated incidents.

(b) Article 15's, letters of reprimand, Court Martial.

(c) Civilian legal problems past and present.

(d) Commander of supervisory comments related to performance of duty or conduct.

(5) Education

(a) Level of education.

(b) Current school enrollment.

(c) Academic, vocational, military, professional education.

(6) Family History

(a) Marital status (spouse working).

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(b) Relationships with spouse and children.

(c) Home life activities.

(d) Financial problems.

(7) Social life

(a) Recreational activities (with whom, when, where).

(b) Hobbies.

(c) Community involvements.

(d) Weekend, evening, vacation activities.

(8) Attitude towards self.

(a) Personal strengths and weaknesses.

(b) Activities client would like to engage in.

(c) How does client see self.

(d) Client identified behavior that does not conform to AF standards/requirements.

d. The social evaluator will prepare a written recommendation for use in the final determination by the unit commander.

e. If the member admits to drug abuse or significant alcohol problems member is entered into the rehabilitation program.

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f. In the case of alleged drug abusers:

(1) The member who has a positive urine test but who cannot be clinically confirmed as a drug abuser or drug dependent and has not provided satisfactory evidence of authorized drug use will be continued in a urine surveillance program.

(2) If the administrative evidence added to the surveillance program indicated drug abuse, the commander should enter the member into the rehabilitation program.

(3) If additional medical or social evidence is completely lacking to support confirmation of drug abuse and surveillance test return the member to full duty.

g. If the social evaluation is conducted as a result of a DWI or concerned drinker, the information should be forwarded to the physician/mental health officer conducting the medical evaluation, for consideration in the diagnosis of alcoholism by the medic and/or to the commander for classification as a problem drinker by the unit commander.

h. The demographic data gathered may be used in the intake interview if the person is entered into the rehabilitation program.

5. Discuss the essential elements of documentation for intake interviews with drug and alcohol abusers.

a. The intake interview deals primarily with three objectives

(1) Orienting the client to the rehabilitation program.

(2) Obtaining necessary demographic data for reporting purposes.

(3) Defining issues and attitudes as they pertain to the individual and the Air Force.

b. The purpose of the intake interview is to gather facts and not to conduct therapy.

c. Preparation for the interview should include:

(1) Rehabilitation orientation.

(a) Provide the client with a copy of the Privacy Act.

(b) Brief the client on the limits of confidential communication.

(c) Orient the client to all phases of the rehabilitation program.

(d) Insure the client is aware of duty and administrative restrictions.

(e) Insure the client is aware of the consequences of not satisfactorily completing the program.

(2) Issues and attitudes.

(a) Review clients substance abuse history including manner of identification.

1. Are there factors within either the client or the environment that contributed to drug/alcohol abuse?

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2. Does the client perceive these situational stresses as troublesome?

3. Does the client have the capability and motivation to develop alternate responses to drug/alcohol abuse?

(b) The way the client enters into the rehabilitation program has great significance as to the client's condition and prospect for completing the rehabilitation program.

1. Understand the total situation, the major contributing stress factors and alternate methods for dealing with them.

2. Establish the time origin of the clients unacceptable military behavior.

a. Is current poor behavior transient?

b. Is current poor behavior changeable?

c. Was there chronic maladaptive behavior existing prior to identification?

3. Diagnosis and prognosis is left up to medical/ mental health authorities.

(3) Interview Guidelines.

(a) The items contained in the guidelines are useful for making recommendations to the rehabilitation committee.

(b) The guidelines are useful for establishing individualized rehabilitation regimens.

d. The documented format should include the following:

(1) Introduction to Social Actions:

(a) Provide the client with an understanding of why they have been referred to Social Actions.

(b) Determine clients feelings about referral to Social Actions.

(2) Orientation:

(a) Clarify role of Social Actions in relationship to AF mission, commander, supervisor, rehabilitation regimen.

(b) Explain the AF drug/alcohol rehabilitation program to include LPCP.

(c) Explain limitations of confidentiality in Social Actions interviews and counselings.

(3) Demographic data and Social History. (This will be the same as the information and format used for the demographic data and social history sections of social evaluations listed previously.)

(4) Clients preferences for regimen:

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(a) Clients attitudes and feelings about types of rehabilitation activities.

(b) Referrals; rehabilitation activities and referral agencies designated as appropriate.

(5) Establishing referrals/ appointments:

(a) Medical,

(b) Legal,

(c) Chaplain,

(d) Financial aid;

others as appropriate.

e. Prior to the initial rehabilitation committee meeting, the client should have completed all referral appointments in order to build an adequate rehabilitation regimen.

f. For individuals self-referred or referred for social evaluation, the information obtained will be helpful in determining whether a need for rehabilitation exists.

6. Identify the essential elements for documentation of an ongoing counseling session.

a. Facts addressed by the counselor and counselee during the session.

b. Counselee's attitude or response during the session.

c. Counselor recommendations. This will preclude a future allegation that the recommendations were never made.

d. Referral actions to other staff agencies, community programs, hospital, etc.

(1) Document follow-up actions to assure that the referral satisfied or addressed the original reason(s) for the referral.

(2) Follow-up to insure that the counselee kept the appointment.

e. Other items include:

(1) dating the session,

(2) writing legibly,

(3) avoiding labels/slang,

(4) keeping entries current,

(5) measuring words carefully,

(6) signing the documentation.

7. Introduce the Summary of Treatment.

a. Identify its purpose: To provide the Social Actions staff at a gaining installation the information necessary to continue effective rehabilitation.

b. Explain the essential elements for documentation in the Summary of Treatment.

(1) Identifying data,

(2) Summary of evaluation,

(3) Summary of Social Actions evaluation,

(4) Summary of Social Actions program, and

(5) Recommended actions.

c. Explain that identifying data includes:

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(1) Name, grade, SSAN;

(2) Age, sex, DOB, race;

(3) AFSC, job title;

(4) Drug/alcohol incidents;

(5) Means of identification; and

(6) Length of service.

d. Explain that a summary evaluation is a brief history of the individual, which includes:

(1) History of present abuse

(a) Pattern of abuse.

(b) Quantity of substance.

(c) Environment of substance abuse; that is, where and under what circumstances, and with whom (if anyone).

(d) Frequency of abuse (how often the substance is taken).

(2) Family history:

(a) Local community:

(b) Any substance abuse by other family members.

(c) Interpersonal family relationships.

(d) Extended family relationships.

(3) Past history:

(a) When abuse began.

(b) Educational background.

(4) Military history:

(a) History of assignments.

(b) Substance abuse history in military service.

(c) Any administrative actions (job changes, LOD determinations, Human Reliability and Personal Reliability Programs, etc.).

(d) Any judicial actions (UCMJ action, Articles 15, reprimands, etc.).

(e) Performance data.

(f) Discuss summary of Social Actions evaluations.

e. Discuss summary of Social Actions evaluations.

(1) Rehabilitation committee evaluations.

(2) Counselor evaluations.

f. Discuss recommendations as as final part of the treatment summary.

APPLICATION

Brief students IAW the lesson plan entitled Base Drug/Alcohol Program Management - Administrative Practicum.

EVALUATION

1. What seven items should be documented by the Social Actions counselor during the intake interview with an identified problem drinker?

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2. Why is it important to document counselor recommendations?

3. What six items should the Summary of Treatment documentation include?

4. When is a Social Evaluation conducted?

CONCLUSION (10 Minutes)

SUMMARY

1. We have discussed the two major sections of a case file which are counseling and administrative sections. We said that administrative information is that documentation related to a rehabilitee's status in the program. Counseling information is documentation relating to the substance of a rehabilitee's counseling. We also discussed security requirements for the maintenance, transfer and final disposition of drug/alcohol abuse case files. These were:

a. categorizing files

b. access to case files

c. storage of files

d. transfer of records

e. disposition of records

f. Privacy Act requirements

g. Methods of conducting and documenting Social Evaluations, Intake interviews, on going counseling, and summaries of treatment.

REMOTIVATION

The information presented today will not only assist you in completion of this course, but will make your job much easier. You will be able to manage your administrative functions much more professionally

through the use of the information presented today, pass IG visits, and help your clients more effectively because of your clearer understanding of his/her case.

CLOSURE

As Social Actions Drug/Alcohol Abuse personnel, you will be tasked with the major responsiblity for implementing good management programs. The program you set up will be the one you will have to utilize.

ASSIGNMENT

Give CTT assignment when appropriate.

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3ALR73430B/30LR7361B/30ZR7364B-IV-1.3 BASE DRUG/ALCOHOL PROGRAM MANAGEMENT
(Drug Rehabilitation Program)

PART II - TEACHING GUIDE

INTRODUCTION (5 Minutes)

ATTENTION

1. Social Actions personnel, in addition to being counselors and educators, need to be managers, effective managers, of their programs.

2. Of prime importance to management is the knowledge of who does what, when, and why within your drug rehabilitation program. Could you answer who does what, when, and why for your program?

MOTIVATION

1. Of all the management schools ever conducted, one important teaching point is common to all. Managers should make the tools they have available work for them, not against them.

2. The subject of this lecture is Social Actions Management: Phases I through V, your tools to management. Of importance to you is how Phases I through V can work for you. Knowledge gained through this lecture will benefit you in three ways:

a. It will provide you adequate management information to insure your program runs smoothly.

b. It will improve your ability to provide a clear, logical, effective treatment program for your clients.

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c. It will insure your program is managed in accordance with USAF and Inspector General (IG) standards.

OVERVIEW

1. Cover the lesson objectives with the class.

2. Develop the lesson chronology.

a. Administrative requirements of Phases I through V of the drug rehabilitation program.

b. Requirement applicable to the limited privileged communication program (LPCP).

TRANSITION

It is clear that in order for a highly complex program, such as the drug/alcohol abuse program, to work, everyone must know exactly what his/her responsibilities are. This "knowing of responsibilities" is one of the largest IG difficulties currently encountered by base-level Social Actions personnel.

BODY (1 Hour 50 Minutes)

PRESENTATION

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1h. CRITERION OBJECTIVE: Identify the administrative procedures for conducting Phase I of the USAF Drug Abuse Rehabilitation Program.

1. Explain that the sources of identification of drug abusers include: investigation/apprehension incident to medical care, and urinalysis, and LPCP.

a. Members may be identified as a drug abuser by investigation, apprehension, or arrest, either by military or civil authoriites.

(1) OSI investigation report or security police incident Form 1569 are forwarded to the unit commander for review.

(2) The commander may request further investigation to support his/her decision to place an individual in the rehabilitation program or discharge the member.

(3) Entry into rehabilitation does not preclude disciplinary actions under the UCMJ or administrative discharges, nor should it be interpreted as grounds for suspension of such actions.

b. Discuss incident to medical care.

(1) Information about or evidence of drug abuse may not be used in whole or part to support punitive action or an administrative separation less than an honorable discharge, when medical treatment is requested by the member.

(2) A member is not exempt from disciplinary or other legal consequences resulting from violation of other laws or regulation, such as the sale or transfer of drugs or possession for such purposes.

(3) Evidence of drug use developed during emergency treatment may, in appropriate circumstances, be used to support punitive action.

(4) Any confirmed evidence can be used to place a person in the drug rehabilitation program.

c. Urinalysis testing.

(1) Evidence that is direct or indirect result of urinalysis testing may not be used for supporting any disciplinary action under the UCMJ or an administrative discharge other than Honorable discharge. However, this does not exempt the member from the consequences of violating other laws or regulations: for example, the sale or transfer of drugs, or possession for such purposes.

(2) Unit commanders and physicians may direct urinalysis testing of members for clinical diagnostic and treatment purposes at any time for suspected drug abuse or deterioration of duty performance or behavior. Age is not a limiting factor.

(3) A urinalysis positive is considered to be valid only after it has been clinically confirmed by a physician.

(4) Social actions, and others may perform a social evaluation to help in the confirmation process.

(5) AFR 160-23 and AFP 160-33 give specific guidance on the confirmation process. Additional information on the urinalysis testing program will be covered in a later unit.

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(6) When a urinalysis is confirmed, the hospital/dispensary prepares AF Form 422, Physical Profile Series. They annotate the type of drug abused as prescribed by medical regulation, and forward this form to the unit commander and social actions.

2. Explain information concerning a commander's decision to formally identify a person as a substantiated drug abuser.

a. State the following information concerning information that may be used for identification of drug abuser.

(1) The identification of an individual as a "substantiated drug abuser" for the purpose of entry into rehabilitation does not require an advance judicial or medical determination except in the case of incident to medical care.

(2) It may be a factual determination by the unit commander based on all available evidence, including the result of a urine test or the individual's own admission.

(3) The fact that known evidence would not be admissible in a judicial or administrative proceeding does not destroy the value of the evidence in identifying an individual for entry into the rehabilitation program.

b. Aids in helping the unit commander in making a decision are:

(1) The rehabilitation committee,

(2) social evaluations,

(3) urinalysis testing

(4) further investigations and,

(5) other staff agencies' input.

c. Emphasize that identification as a drug abuser automatically enters a member into the rehabilitation program, with the following exception:

(1) In cases where members are involved in the personal use or possession for personal use of marijuana, the immediate commander will evaluate each individual to determine if rehabilitation is appropriate. Where an individual is not identified for entry into rehabilitation, the commander should not remove the member normal duties. Other administrative personnel actions may apply at the commander's discretion, such as actions under the provisions of Air Force Regulation 35-32. Each case must be evaluated against the following criteria:

(a) A urine test within twenty-four hours of the marijuana-related incident to determine whether any other type of drug abuse has occurred.

(b) A determination of whether the member was under the influence of or used marijuana on duty.

(c) A review of the member's record to determine whether past behavior or performance has been documented as substandard. Consider all the available facts.

(d) Determination of whether it is a second or subsequent incident of marijuana use or possession for use. Use AFR 35-32 provisions (UIF's) to make this determination.

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(e) An investigation, when appropriate, to determine whether the drug use extends beyond the simple use and/or possession of marijuana.

(2) After review of the information obtained as a result of the above, the commander will determine whether rehabilitation in accordance with AFR 30-2, paragraph 4-25 is warranted. A decision as to whether rehabilitation is warranted or not in no way relieves the commander of his/her responsibility to determine whether disciplinary action is appropriate. If an individual is not placed in rehabilitation, the commander should not invoke those administrative and personnel sanctions normally associated with rehabilitation status.

(3) The above policies do not apply to Air Force members on flying status or having Sensitive Compartmented Information (SCI). Considerations of safety and security provide less latitude regarding illegal and improper use of drugs. Therefore, the immediate commander will temporarily remove such persons from duties involving flying (Air Force Manual (AFM) 35-13) and/or temporarily remove SCI access (USAFINTEL 201-1) for any marijuana use/possession. Members will be entered into rehabilitation because of failure to meet standards due to drug abuse.

3. Explain the drug administrative identification procedures.

a. Unit commanders identify drug abusers by level of abuse (experimenter, user, addict, possessor, or supplier) and by type of drug abused (cannabis, LSD, other hallucinogens, amphetamines, barbiturates, methaqualone, opiates, cocaine, or other drug). The following procedures and guidelines apply: (Direct students to look at an AF Form 1612.)

b. Unit commanders must initiate the AF Form 1612, on the date of identification of a member as a substantiated drug abuser. If identification is not yet substantiated, complete Section I. If identification is substantiated, complete Section II. In completing Section II, the unit commander will indicate the predominant drug of abuse and the level of abuse as defined above, after counseling with the rehabilitation committee if necessary. The unit commander will make an appointment for the member's social actions intake interview. Do not initiate AF Form 1612 for members considered for, but not entered into, rehabilitation, per paragraphs 4-20b and c.

c. AF Form 1612 will be prepared by the unit commander in an original and four copies. Comply with the procedures in figure 4-6. Distribute as follows:

(1) Original copy one and copy two are forwarded to the social actions office.

(2) Copy three is given to the member identified theron and serves as official notification of entry into the rehabilitation program.

(3) Copy four is retained by the unit commander for suspense of follow-up actions, or destroyed if no further actions are required.

d. The social actions office, drug and alcohol abuse control officer or NCO will complete the following on receipt of AF Form 1612 from the unit commander:

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(1) Review the form and annotate the appropriate Advanced Personnel Data System (APDS) coding in Section II for substantiated drug abusers.

(2) Initial coordination record and forward copy one of the AF Form 1612 to CBPO/DPMQA.

(3) Initiate the member's rehabilitation case file and place the original AF Form 1612 in it.

(4) Forward copy two to the medical services personnel for information in the evaluation process and for use by the urinalysis testing program monitor. Copy two will not be filed in the member's medical records.

e. The CBPO/DPMQA personnel will use copy one to initiate APDS and other personnel actions. File copy one of AF Form 1612 in the member's UIF folder after all required personnel actions are completed.

f. If the unit commander determines that a member's identification and entry into the rehabilitation program was in error he or she will complete Section III on a new AF Form 1612. Justify in the remarks block the removal from the rehabilitation program. Prepare and distribute two copies of the form as follows:

(1) The original copy to the social actions office. The drug and alcohol officer or NCO will coordinate and forward it to CBPO/DPMQA for appropriate action to remove APDS codes and other personnel data entries. The case file will be destroyed at this time.

(2) Copy two will be given to the member as official notification of removal from rehabilitation.

g. When a member has successfully completed the rehabilitation program, the unit commander will initiate a new AF Form 1612, complete Section III, and process it in accordance with paragraph c(1) through (3).

h. Social actions personnel will request a computer printout each month from CBPO/DPMQA. This printout will list all individuals identified in APDS with a Substance Abuse Control Identifier (SUBS-AB-CNTL-ID) and will be used for the proper management of the rehabilitation program, to verify APDS entries.

i. The CBPO/DPMQA will establish internal control procedures to prevent unauthorized personnel from having access to APDS code. Access to substance abuse control data is limited to personnel and functions listed in figure 4-6.

4. Explain the control of officers and officer candidates identified as drug abusers. Officers and potential officers have an obligation to maintain the highest standards of discipline and military decorum. The nature of their duties is such that the effects of drug abuse could have particularly unfortunate results. Therefore, retention is not appropriate.

a. Officers. Enter officers into rehabilitation and provide treatment and counseling, as necessary, pending disposition. Provisions for treatment of drug dependency (paragraph 4-42) apply.

b. USAF Academy Cadets. Retention is not appropropriate for cadets. Pending departure from the Cadet Wing, a cadet identified as a drug abuser is provided counseling and medical treatment

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as needed. Follow appropriate referral procedures for those former cadets who, pursuant to 10 U.S.C. 9348(b), are ordered to active duty in an enlisted grade. These individuals are transferred PCS and entered into appropriate rehabilitation programs.

c. Airman Education and Commissioning Program and Officer Training School. Pending disposition, members of these programs are provided rehabilitation and counseling as described in paragraph 4-40a above. Drug and alcohol abuse control personnel must insure appropriate referral procedures for those members being transferred PCS and returned to enlisted status (paragraph 4-43).

d. ROTC and Medical Scholarship Personnel. These individuals are not carried on the actiye rolls of the Air Force. Pending disenrollment for drug abuse, detachment commanders urge them to seek treatment in civilian programs.

e. Military Dependents and Civilian Employees. Drug and alcohol abuse control personnel may provide rehabilitation and referral services for military dependents and civilian employees. When these persons are otherwise authorized medical care, they may receive medical care incident to rehabilitation. Management procedures for civilians are in AFR 40-792.

5. Outline requirements applicable to the CBPO. In addition to entering the AF Form 1612 data into the APDS the CBPO also does the following:

a. Automatically initiates an Unfavorable Information File (UIF) and files the copy of the AF Form 1612 in the UIF folder. Also a UIF Code is entered in the APDS. (IAW AFR 35-32.)

b. Assignment Availability Code 11 must be entered to prevent reassignment of a rehabilitee. AFR 39-11 freezes enlisted personnel in Phases I through V from reassignment.

c. A reenlistment code is also input into the APDS which prevents reenlistment.

d. These and other personnel dispositions are discussed in a later lesson.

6. Explain the requirement applicable to handling drug abusers in civilian confinement.

a. Drug abusers in civilian confinement who will not be returned to military control, at a minimum, must be counseled regarding civilian facilities available for release.

b. Where geographic location prevents visiting drug abusers in civil confinement, coordinate with base legal officer to advise member in writing of civilian facilities for treatment after release.

c. Counseling must be documented. A memorandum for record is sufficient documentation.

APPLICATION/EVALUATION

1. When is a member considered to be officially entered into the AF Drug Rehab Program?

2. Under what conditions may a unit commander choose to not enter a drug abuser in the rehab program?

3. What is the routing of the AF Form 1612?

4. What action is social actions required to take in regard to drug abusers in civilian confinement?

PRESENTATION

1i. Identify the procedures for administering the Limited Privileged Communication Program (LPCP).

1. Explain that the purpose of LPCP is to encourage drug abusers to identify themselves so that they may receive treatment and rehabilitation.

2. Air Force policy states the following:

a. Members who voluntarily present themselves to the unit commander, first sergeant, social actions, or medical personnel for treatment and rehabilitation for personal use of drugs are exempt from:

(1) Disciplinary action under the UCMJ for such disclosed personal use or possession for personal use of drugs, and

(2) Administrative discharge less than an Honorable Discharge based, in whole or in part, upon such disclosed personal use or possession incident to personal use.

b. These exceptions apply only to service members who voluntarily reveal the nature and extent of their drug involvement and seek treatment before being apprehended, placed under investigation or advised of a recommendation for administrative separation because of their use of drugs. These exemptions apply whether or not the person is entered into the rehabilitation program.

3. Explain the importance of and the procedure for developing a LPCP agreement.

a. We recommend that your social actions office develop a LPCP agreement in conjunction with your legal office.

b. The agreement or contract serves several purposes:

(1) Insures the client thoroughly understands LPCP before divulging information about his/her abuse of drugs.

(2) Documents the fact that the client was thoroughly briefed on the provisions of LPCP.

(3) Documents the date/dates which the client first sought help under LPCP.

(4) Documents the unit commander's certification that the client was eligible for LPCP on that date.

c. State the procedure for developing the LPCP contract/agreement.

(1) Develop a contract/agreement using AFR 30-2, para 4-23 as the guide. Include all the policy information from AFR 30-2.

(2) Include a space for the member's signature; the first sergeant, medic, or social actions specialist's signature; and the unit commander's certification that the person is eligible for LPCP protection.

(3) Have the agreement/contract approved by the local Staff Judge Advocate, to insure legal sufficiency.

(4) Suggest you use a local form (if your MajCom has not already developed one), to insure proper distribution of the agreement/contract to unit commanders, medics and social actions.

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(5) Insure that unit commanders, first sergeants, and medical personnel have an adequate supply of the LPCP agreement, and are properly briefed on the program and the use of the agreement.

d. Explain that after the agreement is completed by the first sergeant, social actions, or medical personnel, it should be forwarded in three copies to the unit commander for his/her certification that the person meets the eligibility criteria.

e. Once certified, the distribution of the agreement/contract is as follows:

(1) 1 copy to the client.

(2) 1 copy for the unit commander's files.

(3) The original copy to social actions to be filed in the case file.

4. Explain the steps social action personnel should take in counseling/advising an LPCP applicant concerning program entry.

a. When a client initially indicates he/she is interested in LPCP, or is seeking help for a drug problem, explain to the client the provisions of LPCP. Do not solicit any drug abuse information before explaining the program completely, with all its ramifications. Stress the difference between administrative and UCMJ actions. LPCP only protects from UCMJ and discharge actions under less than an Honorable discharge. Reiterate that LPCP covers only past personal use or possession incident thereto--not sale.

b. Allow the client to read the LPCP agreement/contract. Answer any questions the client may surface.

c. If the client chooses not to participate, and he/she has not given you information regarding his/her own drug abuse; and he/she has not given you reason to believe that he/she is currently abusing drugs, the client may choose to leave.

d. If, on the other hand, the client volunteers information about his/her drug abuse, or gives you reason to suspect drug abuse, then you have a responsibility to report this occurrence to the unit commander. The information you gained from the individual under these conditions, however, is still exempt under the LPCP, whether the person enters the rehabilitation program or not. The commander may use this information to direct a urinalysis, confirm other reports of drug abuse, or initiate an investigation.

e. If the member wishes to participate and signs the LPCP agreement, your next step is to find out from the unit commander whether the client is under investigation. Members are considered under investigation when a written request for investigation has been made to either the security police or the AFOSI by the unit commander. In determining whether an individual is under investigation, the unit commander is the sole point of contact for social actions, medical personnel, and first sergeants.

f. If the member is already under investigation,

(1) The unit commander has three options:

(a) Enter the member into drug rehabilitation program under investigation, apprehension and arrest, and follow the normal procedures.

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(b) Enter the member into drug rehabilitation under LPCP because there is not enough evidence at this time to stand up in a court martial or administrative discharge.

(c) Continue investigation until additional information is available to support administrative discharge or court martial. Information gained from LPCP cannot be used to support a court martial or discharge less than honorable.

(2) Inform the unit commander of the following:

(a) Restate the purpose of LPCP is to encourage member to voluntarily seek treatment and rehabilitation for their personl drug use.

(b) If decision is postponed, then you will tell client LPCP does not apply to him/her at this time. Client will suspect he/she is under investigation and may stop using drugs and no evidence may be obtained to support administrative discharge.

(c) Suggest to the unit commander one of the following:

1 Allow individual to enter LPCP and gain LPCP protection.

2 Enter the client into program based on available data. The identification of an individual as a "substantiated drug abuser" for the purpose of entry into rehabilitation does not require an advance judicial or medical determination, except in the case of identification incident to medical care. It may be a factual determination by unit commander based on all available evidence including the results of a urine test or the individual's own admission.

(3) If unit commander decides on entering the individual into the rehabilitation program, begin intake interview and refer to unit commander.

(4) If unit commander wants to postpone action and continue investigation, inform client LPCP is not available at this time and refer the individual to his/her commander and legal office. Do not solicit further drug information.

g. If the person is eligible for LPCP, then you should inform the unit commander and begin the intake interview. The data you collect for the intake interview can be used to help the commander determine whether the member is actually a substantiated drug abuser.

h. When you have finished the intake, refer the person to the unit commander for counseling and administrative action. The unit commander should make an appointment for the member to have a medical evaluation. This is a program requirement, and the information from the medical evaluation is needed for a Phase III evaluation.

i. Once the commander formally identifies the LPCP member as a substantiated drug abuser, the member follows the same steps as other drug abusers.

j. If at any time during the intake or counseling the person mentions sale or other non-personal use or possession, LPCP does not apply, and this information may be used against the person.

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5. If first sergeants or medics perform the initial LPCP interview, they should refer the person to the unit commander, who should, in turn, refer the person to Social Actions with an AF 1612 if the commander

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believes the person is a drug abuser. Social Actions then performs the intake interview and the usual procedure is followed.

6. Personnel involved in administering the LPCP are not in the position of granting or dispensing LPCP protections. Their proper role is insuring that personnel are fully counseled on drug abuse. If members volunteer information on personal drug use or possession incident to such use in accordance with paragraph 4-23 of AFR 30-2, they are protected by Air Force policy.

7. Occasionally personnel in career fields or jobs they do not like will attempt to manipulate their way out of their job by using LPCP to disqualify them from their job. If you suspect this is being done; that a person asking for LPCP protection has not abused drugs, but is simply manipulating his/her way out of an "undesirable" job, then you should report your findings to the unit commander. The unit commander has the authority to decide whether a person is a substantiated drug abuser or not; The commander does not have to take the word of the LPCP applicant. A urinalysis, medical evaluation, and social evaluation will help determine if the person is actually a drug abuser or is simply manipulating his/her way out of an "undesirable" job.

APPLICATION/EVALUATION

1. Who can an AF member voluntarily present him/herself to for LPCP protection?

2. What is the difference between administrative action and punitive action? Why is it important to explain this to a person interested in LPCP?

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3. Can LPCP be denied any AF member? Under what conditions?

4. Why is it necessary to send a locally developed LPCP contract for a legal review?

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PRESENTATION

1j. Identify the administrative procedures for conducting Phase II of the USAF Drug Abuse Rehabilitation Program.

1. Explain the purpose of Phase II is detoxification of an air force member if a competent medical authority determines that he/she is a drug-dependent individual.

2. The primary office of responsibility (OPR) for Phase II is the hospital/dispensary.

3. All treatment given to an individual in detoxification is recorded in the medical records of the individual and not in social actions case file. Access to medical records is controlled by the Director of Base Medical Services (DBMs) and not the attending physician.

4. Drug-dependent individuals are detoxified at the nearest medical facility that have capability. Detoxification is determined by competent medical authority and accomplished in a drug free environment.

5. When local base hospital does not have the capability to provide a drug free environment, aero-evacuation may be necessary to get the individual into a drug free environment.

6. Social Actions will make sure case files are documented with entry and exit dates of each member entered into detoxification. Social Actions will also assist the hospital in aero-evacuation operation by coordinating with the family of the individual and any other agencies.

7. Explain that drug-dependent individuals who are non-extended active duty (EAD) members of the USAF Reserve will be counseled and referred to appropriate Government or civilian agencies for which the member may be qualified.

a. Reservists are not eligible to participate in active-duty Air Force rehabilitation programs.

b. Non-EAD Reservists who are in a rehabilitation program will be transferred to the stand-by Reserve until determined by competent medical authority that they are qualified for normal duty.

c. Assignment of non-EAD Reserve members to active duty for training for the purpose of rehabilitation is not authorized.

APPLICATION/EVALUATION

1. When is a member officially entered into the drug rehabilitation program?

2. What are the UIF requirements when a drug abuser is identified?

3. What items are recorded in Social Actions case files for Phase II?

4. Who is OPR for Phase II?

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1k. CRITERION OBJECTIVE: Identify the administrative procedure for conducting Phase III of the USAF Drug Abuse Rehabilitation Program.

1. The purpose of Phase III is to determine the appropriate medical treatment and disposition of each individual. A medical evaluation is mandatory for substantiated drug abuser.

2. Explain that Phase III will be completed within 10 work days of the identification of a member as a substantiated drug abuse. This includes:

a. Medical evaluation by a physician.

b. Intake interview or social evaluation by social actions.

c. Other staff agencies interviews and input.

d. A meeting by the rehabilitation committee to recommend action on the individual,i.e., separation or rehabilitation.

e. Commanders decision to separate or rehabilitate an individual and what administrate actions must be taken.

3. Explain the criteria for assisting the commander in making a decision on rehabilitation or separation of an individual.

a. The number and nature of member's offenses; the category of abuse (experimenter, user, addict, supplier or possessor).

b. Member's age and background including duty performance, conduct and achievements.

c. Member's attitude, motivation, and potential for further military service.

d. The extent to which a member's drug abuse has affected or may affect his/her duty performance or conduct, flying potential, health welfare, his/her safety, and safety of other personnel.

e. Evaluation by the rehabilitation committee and other knowledgeable person, as appropriate.

4. Explain that after reviewing all available data the commander can decide whether trial by court martial or other disciplinary action, administrative separation, denial of security clearance or access to classified information, suspension from duties, control roster action or any other action as appropriate.

5. Explain that any action concerning the individual, other than medical, will be documented in the individual's case file.

a. A physician evaluation (profile series change AF Form 422).

b. Entry and exit dates in the Phases.

c. Rehabilitation committee evaluation.

d. All administrative action taken.

6. Explain in the cases of suppliers or drug dependent individuals, the decision to rehabilitate or separate an individual is made for the commander, by regulation.

7. Explain that the USAF Surgeon General requires that special consideration and restrictions apply to any person with a history of verified LSD use or experimentation.

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a. Any verified history of LSD use permanently disqualifies a member for all flying duties, air traffic control activities, and carrying arms.

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b. Any verified history of LSD use permanently disqualifies a member for all duties under the Human Reliability Program (HRP) AFR 35-98.

c. Individuals having LSD intoxication symptoms ("flashback" phenomena) are to be administratively discharged.

d. The word alone of an individual that has used LSD is not sufficient to employ the term "verified History of LSD use". Verification must be by:

(1) Clinical observation, to include written documentation by a physician clearly describing the flashback phenomena.

(2) Verified by official investigation or other competent legal evidence.

8. Document committee evaluations, reported flashbacks and any other related behavior to support administrative discharge action if needed.

9. Explain the procedures to transfer a member to the VA hospital.

a. When members are drug-dependent or addicted as defined in paragraph 4-2, or long-term rehabilitation (over 90 calendar days' treatment before return to duty) is necessary, they must be processed for separation and transferred to a Vetrans Administration hospital for further treatment (see figure 4-5). Transfer actions must be completed no less than 15 calendar days before the effective date of the discharge. (NOTE: A date of separation is established and the VA affords treatment to this date, irrespective of the

character of discharge.) VA treatment subsequent to separation depends on the character of the discharge, not treatment before discharge.

b. Effect transfer to the VA via the Armed Services Medical Regulating Office (ASMRO). OPR for this action is the DBMS.

c. Provide interim treatment for drug-dependent members in local programs.

d. Drug-dependent members must be provided a minimum of 30 calendar days' treatment for this condition before discharge. The 30 calendar days must be consecutive, and every attempt must be made to keep the member free of illegal drug use. Use the following computation guidelines.

(1) Begin with detoxification.

(2) Include time spent in transit to the VA via medical transportation.

(3) Insure that the member remains under military or VA control during the entire 30-calendar-day period.

e. When the member reaches ETS before the completion of 30 calendar days' treatment, the member may request retention beyond ETS to fulfill the requirement.

f. When transferring a member to the VA, the Director of Base Medical Services must insure that the medical transfer provisions of figure 4-5 are met.

g. When members have been transferred to VA facilities, then become so recalcitrant that their presence is disruptive to the operation of the hospital, and VA personnel determine that they are not receptive to further treatment, they are returned to Air Force control by the VA.

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10. Explain that Non-EAD members of the USAF Reserve are authorized to be assigned to active duty for training, for the purpose of medical evaluation (AFR 35-14), when authorized by the AFRES Surgeon (AFRES/SG or ARPC Surgeon ARPC/SG).

APPLICATION/EVALUATION

1. Who is OPR for Phase III?

2. What is the purpose of Phase III?

3. Phase III will be completed within how many work days?

4. When are Social Actions case files forwarded to VA?

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PRESENTATION

11. CRITERION OBJECTIVE: Identify the administrative procedures for conducting Phase IV of the USAF Drug Abuse Rehabilitation Program.

1. Explain the objective of Phase IV is to redirect the behavior of individual rehabilitee so that they voluntarily conform to the Air Force standards of performance and conduct.

2. Explain that not all members identified as drug abusers require Phase IV rehabilitation. The appropriateness of Phase IV rehabilitation is made on an individual basis by the rehabilitation committee, and approved by the unit commander. The committee may recommend that a member be placed directly into Phase V from Phase III, and the commander may approve/disapprove the action.

3. Explain that in extenuating or unusual circumstances, following the completion of Phase III, the unit commander may direct a members' removal from rehabilitation. Such decision must be based on a recommendation by the rehabilitation committee; or on the unit commanders judgement that the member's entry was in error or that rehabilitation is not required.

4. Explain that in cases where members are removed from rehabilitation because entry was in error, destroy or correct all APDS, UIF or other personnel records entries, including destroying the rehabilitation case file.

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5. Social Actions is office of primary responsibility (OPR) for Phase IV.

6. Phase IV is nonmedical. The Director of Base Medical Services, (DBMS), designates an officer (usually the Phase III evaluator) to act as a consultant on Phase IV to drug/alcohol abuse control personnel.

7. Explain drug/abuse control personnel insure the needs of Phase IV members are adequately met by both individual and group counseling, inhouse services or referral to either on or off base services agencies.

8. Explain that Phase IV normally does not exceed 45 days; however, personnel will not be retained in Phase IV more than 90 days after the Phase III evaluation.

9. Explain Phase IV regimen must be designed to facilitate modification of behavior so that the clients may voluntarily adapt to military life and meet AF standards as quickly as possible, or assist them in their transition into civilian life. This may be accomplished through individual and/or group counseling, and appropriate referrals.

10. Explain Social Actions will coordinate and effect the rehabilitation regimen of clients throughout the rehabilitation period. This includes making appropriate regimen appointment for the clients and recording all pertinent feedback pertaining to clients from referral sources. This may include:

a. Appointment with Mental Health Clinic to provide therapy and family counseling.

b. Weekly appointments with Social Actions to observe behavior and progress through group meeting.

c. Being observed by the unit commander and supervisor for job performance.

d. Appointments with Chaplain for marital counseling, if client and wife have marital problem.

e. Insuring that unit commanders have scheduled the rehabilitee for Rehabilitation Urinalysis Testing.

11. The rehabilitation committee must meet as frequently as necessary to minimize delay in rehabilitation of the client, if the client shows signs of relapses. Each rehabilitation committee member's progress evaluation of the client is used to determine if the member is meeting the rehabilitation regimen or a need to revise the regimen.

12. Document in the individual's case file, entry and exit dates in Phase IV, the regimen, all actions recommended and approved by the unit commander, and other action that is necessary to support rehabilitation or discharge.

APPLICATION/EVALUATION

1. What is the purpose of Phase IV?

2. Is Phase IV mandatory for all rehabilitees?

3. Who may approve the bypass of Phase IV?

4. What is the minimum number of times the rehabilitation committee has to meet during Phase IV?

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PRESENTATION

1m. CRITERION OBJECTIVE: Identify the administrative procedures for conducting Phase V of the USAF Drug Abuse Rehabilitation Program.

1. Explain that Phase V is the last and final Phase of the drug rehabilitation program. The primary purpose of Phase V is (follow on support) to provide clients with an opportunity to demonstrate they can conform to Air Force standards of conduct and performance.

2. Explain Social Actions is the office of primary responsibility for Phase V.

3. The duration of Phase V is at the discretion of the unit commander, bases on the recommendation of the rehabilitation committee, (not to exceed 1 year from date of entry into Phase V).

4. Explain that members in Phase V must be assigned to productive jobs in their primary or secondary AFSCs, if at all possible. They are not to be assigned to special quarters or work units, released from military duties, or regularly assigned to menial, unproductive tasks. However, this does not preclude actions required under AFM 35-98 or AFR 35-1, 35-13, 35-99, 39-4, or 205-32, as applicable. The primary purpose of Phase V is the members' demonstration that they can perform their duties and meet their responsibilities. Failure to meet this requirement is a cause for separation.

5. Explain that identified drug abusers must successfully complete Phase V to be retained in the Air Force. Rehabilitees must show a pattern of consistent improvement or demonstrate an inability or unwillingness to be rehabilitated within this program, should

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normally cause the unit commander to seriously consider separating the member from the Air Force.

6. Explain that other than the quarterly evaluations and urine testing as prescribed in AFR 160-23, there are no requirements in Phase V. Depending on individual circumstances, some members may require a supportive program of counseling, while others require nothing more than the knowledge that they are being observed and evaluated. The objective of Phase V is to facilitate return to duty with satisfactory performance and conduct. This is the measure of success for Phase V.

7. Explain Social Actions coordinate the efforts of the clients during Phase V, Follow-On-Support. Feedback should continue throughout Phase V, from the following:

a. Supervisory evaluations (minimum quarterly-suggested monthly).

b. Urinalysis test (mandatory).

c. Individual counseling, (as needed). May help deal with individual problems/crisis.

d. Group counseling (as needed). May help deal with work adjustment problems, and social needs.

8. Explain that inputs into Phase V is received from permanent change of station (PCS) gains, (Overseas returnees) and local rehabilitation (Phases III or IV). This distinction will be important for your AF Form 3017 (HAF DPX 711- Report).

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9. Explain that failure to meet appointments, perform duties satisfactorily, disengage from the illegal or inproper use

of drugs, or meet the standards in AFR 30-1; and other directives must be documented. Documentation may be used to reflect accurately the member's substandard behavior or performance, and may result in discharge action.

10. Explain that when a member in the rehabilitation program is transferred PCS, the drug and alcohol abuse control office will reproduce a complete copy of the rehabilitation case file and forward it to the gaining drug and alcohol abuse control office. (The original rehabilitation case file will be maintained by the losing drug and alcohol abuse control office.) The case file forwarded to the gaining organization must arrive no less than 2 weeks before the member's arrival. When a member is assigned TDY for longer than 30 calendar days, the drug and alcohol abuse control office must send a "Summary of Treatment" letter to the gaining drug and alcohol abuse control office. On completion of TDY, the servicing social actions office will provide a summary of member's progress to the member's home base social actions office.

11. Explain if a case file have not arrived prior to the rehabilitees arrival, Social Actions should request the records through a telephone call, followed by a letter to the losing Social Actions office (CONUS). If the rehabilitee is returning from overseas a message or letter should be sent requesting the case file.

12. Social Action should inform unit commanders of arriving individuals once they are identified on the monthly DESIRE from CBPO. Unit commanders should make appointment for the matter with Social Actions as soon as the individual signs in to the unit.

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13. Explain that the rehabilitation committee evaluates each Phase V rehabilitee at least quarterly for the duration of the phase. When an evaluation reveals the member is fully rehabilitated, the unit commander directs removal of restrictions on reenlistment or reassignment and elimination of tracking data in APDS as appropriate (HRP/PRP disqualification data is managed under AFM 35-98 and AFR 35-99). Failure to be recommended for unconditional retention at the final evaluation is a basis for the initiation of separation action (see paragraph 4-38).

APPLICATION/EVALUATION

1. Who recommends a member for Phase IV or V? Who approves the recommendations?

2. What procedure should be developed by social actions and unit commanders in regard to PCS gains who are in Phase V?

3. When are treatment summaries forwarded? When are case files forwarded?

4. What actions are mandatory in Phase V?

CONCLUSION (5 minutes)

SUMMARY

We've looked at the requirements of the USAF Drug Rehabilitation Program, together with some helpful hints on how to make your program run smoother. LPCP counseling which we've covered today is a tricky area, involving knowledge of the policy, and a good deal of judgment and legal advise.

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REMOTIVATION

If you know the requirements of each phase of the Drug Rehabilitation Program, together with the helpful hints, your program will run smoother, it will pass IG inspections, and, best of all, it will encourage more drug abusers make decisions about their lives and rehabilitate themselves with your help.

CLOSURE

ASSIGNMENT

Give complementary technical training assignment, when appropriate.

3AlR73430B/30LR7361B/30/R7364B BASE DRUG/ALCOHOL PROGRAM MANAGEMENT
(Program Evaluation and Urinalysis Program)

PART II - TEACHING GUIDE

INTRODUCTION (5 Min)

ATTENTION

How do you know whether you're doing a good job? How do you tell what needs to be done? What is Social Actions' role in the base urinalysis program?

MOTIVATION

1. These are some of the questions we'll try to answer during this hour.

a. First, when you get to the field you'll need to know what the needs of your particular base are, how to prepare for the IG, and how to tell whether you're doing a good job.

b. Second, you will need to know how the urinalysis testing program works in order to:

(1) Explain the program to base level students.

(2) Explain the requirements placed on rehabilitees.

(3) Know how you fit into the identification process.

(4) Know when to recommend commander-direct testing.

OVERVIEW

1. Cover the lesson objectives with the class.

a. Program evaluation

b. Urinalysis program

c. Urinalysis test monitor responsibilities and major reporting procedures.

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TRANSITION:

We shall begin by looking at the "Why" of evaluation.

BODY (40 Min)

PRESENTATION

1u. Identify the four classification and five steps of program evaluation, and four evaluation tools which can be effective in Social Actions Drug/Alcohol Abuse Control Programs.

1. Explain the difference between evaluation and descriptive analysis.

a. Evaluation process is based on criteria or standards such as Air Force directives.

b. No standards are used in a descriptive analysis.

2. Discuss four classifications of program evaluation.

a. Needs assessment determines what is needed by an evaluation.

(1) This may include:

a. Target Population

b. The kinds of problems which exist (real or perceived.)

b. Program planning designs the kinds of plans and activities which would best serve the needs identified earlier.

c. Ongoing evaluation is a continuing process which may involve:

(1) Implementation of the plans and programs developed.

2.

(2) Progression rates, such as those timetables found in the Air Force Social Actions Affirmative Action Plan.

d. Outcome evaluation is similar to follow-up. It provides information regarding the degree to which criterion standards were met by the plans and programs implemented.

3. Identify and explain the five steps to follow when designing an evaluation program.

a. Define the objectives of the program; that is, what do you want to get out of the program?

b. Establish the measurement criteria (for example, against what directive, regulation, policy, message, etc.).

c. Develop systematic plans for collecting and organizing data -- how it is going to be done. A survey may be appropriate.

d. Provide ongoing evaluation of the program to redefine the objectives or measurement criteria, when necessary.

e. Provide outcome evaluation - utilize the criteria established to determine the success of the program.

2. Explain that evaluations are useful tools to insure that program objectives are being met. An evaluation may have one or more of the following purposes.

a. To provide feedback on specific aspects of the program.

b. To assist in program development and planning.

c. To insure that the program is functioning in accordance with established directives.

d. To validate the quality of a program.

4. Explain that there are several types of evaluation techniques, and each has a specific objective. Social Actions personnel are usually concerned with four evaluation tools:

a. Procedure checklists are designed to insure the proper steps are covered in any function or operation.

(1) In these checklists, the specific order in which procedures are covered may or may not be important, depending on the type of operation.

(2) Procedure checklists are particularly helpful when there are many aspects of a program with a great deal of steps.

(3) Each item on a checklist should be cross-referenced with the applicable directives and specific paragraphs.

b. Self-inspection checklists assist in maintaining a quality program.

(1) This type of checklist insures that all aspects of a program are in operation and serves as a reminder if they are not.

(2) Since Social Actions is the OPR for monitoring the effectiveness of the program, the responsibilities of all agencies should be included.

(3) Remember that the responsibilities of the commander are equally shared by Social Actions as program functional managers.

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(4) An inspector's checklist is similar to this type; however, it provides for a discriminating element to determine the quality of programs.

(5) Again, when establishing a checklist, cross-reference all items with applicable directives and paragraphs.

c. Education presentation evaluations determine whether or not students are progressing toward desired learning outcomes (criterion objectives).

(1) An instructor may evaluate students during presentations by maintaining eye contact and asking questions.

(a) Eye contact enables an instructor to determine attentiveness, and whether or not complex ideas are getting across. Body language, such as facial expressions, is a clue to a student's receptiveness to the information.

(b) Questions during or at the end of a presentation reveal misconceptions and clarify ideas.

(2) Student critiques evaluate training, student group activities, and base support facilities and services.

(a) Consider the following when developing a student critique.

1 Names, if requested, should be optional to encourage students to be honest and open if confidentiality is desired.

2 Critique questions should be short and direct to the point.

3 Avoid asking questions which encourage a one-word answer response, such as "Did you like the program?

4 A rating system, such as satisfactory/unsatisfactory, or a range from poor through very good is often used.

(b) Encourage students to complete the critique immediately after the lesson. Occasionally, a student will

request that he/she be allowed to keep the form for a time to organize his/her thoughts. Chances are, you'll never receive it.

d. Questionnaires are used to obtain specific information about a particular subject, attitudes, or patterns.

(1) Once the test population is determined; that is, whom you are trying to reach, the CBPO will assist in establishing a random distribution. Random distributions are generally considered to be the most equitable.

(2) Coordinate the questionnaire with the office of information. That office will assist in insuring that the most benefits are obtained from the survey. Remember, substance abuse by service members can constitute adverse publicity.

APPLICATION/EVALUATION

1. Why is ongoing evaluation important.

2. What are four specific evaluation tools for Social Actions?

PRESENTATION

1v. CRITERION OBJECTIVE: Identify urinalysis requirements for the Air Force commander-physician directed, surveillance, drug rehabilitation, and no-show testing programs.

1. Explain that the purpose of urinalysis testing used in the Air Force today: To assist in identifying drug abusers and monitor the progress of rehabilitees.

2. Review the Air Force Policy on urinalysis testing.

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a. The urinalysis testing program is conducted in accordance with AFR 160-23.

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b. Evidence obtained from urinalysis may be used in discharge actions resulting in an Honorable Discharge. Evidence developed by, or as a direct or indirect result of, urinalysis may not be used for supporting, in whole or in part, any disciplinary action under the UCMJ or an administrative discharge other than Honorable Discharge. However, this does not exempt the member from disciplinary or other legal consequences that result from violations of other laws or regulations; for example, the sale or transfer of drugs, or possession for such purposes.

c. Military members may be compelled to provide urine samples for clinical diagnostic and treatment purposes. Members who refuse to provide a urine sample for clinical diagnostic and treatment purposes may be given punitive action for failure to obey a lawful order.

3. Explain commander-physician directed Testing. Explain that unit commanders and physicians may direct urinalysis testing of members for clinical diagnostic and treatment purposes at any time for suspected drug abuse or deterioration of duty performance or behavior. Age is not a limiting factor. Drug/Alcohol personnel should recommend to the senior installation commander, through the chief of Social Actions, appropriate levels of commander directed and unit sweep urine testing.

a. Explain Unit Sweeps. The abuse of <u>hard</u> drugs can have a serious impact on the mission and on the behavior and job performance of individuals using drugs. In locations where there is high availability of <u>hard</u> drugs, and law enforcement and investigative trends indicate the possibility of sifnificant levels of drug abuse, commanders should consider the use of unit sweep testing for personnel 25 and under. Stress judicious use of urinalysis testing.

b. Explain individual incident Testing. In view of the fact that drug abuse often contributes to substandard performance and behavior, commanders should consider testing members involved in incidents which might indicate use of drugs such as the following:

(1) Assult
(2) AWOL
(3) Failure to go
(4) Single driver or other suspicious motor vehicle accidents
(5) Significant safety violations
(6) Disobeying a lawful order
(7) Failure to progress in OJT
(8) Larceny

These examples may be caused by a number of reasons. However, if other behaviors indicate substance abuse, the commander should consider directing a urinalysis test. Use only when there is a high probability of a positive.

4. SURVEILLANCE PROGRAM. Explain that the surveillance program is used to determine whether the initial positive received in a previous urinalysis is valid. The urine surveillance program consists of mandatory submission by a service member of a minimum of eight urine specimens per month at random intervals for a minimum of one month.

a. If at the conslusion of the surveillance period all tests have been negative, the member may be released from the program.

b. If any surveillance test is positive during the surveillance period, the member must be reevaluated by returning through the evaluation sequence.

c. Participants in the urine surveillance program will be reported as confirmed drug abusers only after

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receipt of a subsequent positive urine test and reevaluation with clinical or social confirmantion as a drug abuser.

5. Explain drug rehabilitation program testing. Explain that rehabilitation program testing is conducted to monitor the progress of participants and to identify recitivism (relapses). Explain the following drug rehabilitation program procedures:

a. TESTING RATE:

(1) Phase I - IV is four per month.

(2) Phase V - two, randomly selected.

b. Explain program member change notification. Explain that social actions notifies the test monitor of rehabilitation program member changes when:

(1) Rehabilitees enter Phase V. (So that the testing rate can be changed.)

(2) Rehabilitees are received from other bases. (TDY or PCS).

6. Explain no-show testing. Personnel who fail to show for testing and to not have a valid reason acceptable to the unit commander are tested three tests per week for 4 consecutive weeks to determine if they are involved.

APPLICATION/EVALUATION

1. What is the purpose of urinalysis testing?

2. When should a commander consider a unit sweep? An individual event test?

3. What are the urinalysis rates for the surveillance, no-show, and rehabilitation testing?

PRESENTATION

1w. Identify the responsibilities of the urinalysis test monitor and the major reporting procedures for test results, and the confirmation process.

1. Explain that as overall monitors

for the Base Drug Program Social Actions monitors the overall effectiveness of the urinalysis testing program for the senior installation commander. Therefore, it behooves social actions personnel to know the requirements and responsibilities of the drug rehabilitation program.

2. Explain that the test monitor is appointed by the commander and is responsible for:

a. Supervision of collection facilities.

b. Shipping of the samples.

c. Monitoring system for timeliness of collection.

d. Notifying units of positive results.

e. Miscellaneous duties, such as ordering supplies.

3. Explain that urine samples are forwarded to a regional laboratory for testing within thirty-six hours.

4. Describe the reporting procedures.

a. Laboratory results are reported within 48 hours of receipt of the specimen either electrically or telephocically.

(1) Positives confirmed, with a statement that others are negative.

(2) Written follow-up report dispatched simultaneously to originating agency.

Unit commander, and social actions are notified by the test monitor.

c. Confirmation process begins. (Refer to Atch 1.) 832

(1) Physician interviews individual for clinical daignosis of abuse.

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(2) No further action is taken if prescription drug is involved.

(3) If drug use is disagnosed, commander must enter the individual in the program.

(4) If drug use is denied, and no symptoms are evident, surveillance testing begins.

(5) Social Actions completes a social evaluation, based on:

(a) Duty performance.
(b) Conduct.
(c) Personnel record.
(d) Demographic data.
(e) Admission or denial of use. This may cause program entry.

d. If test is positive during surveillance period, the commander and Social Actions are notified again, the individual is reevaluated, and the commander may initiate entry into the program.

5. Describe common ways personnel have used to attempt to compromise the system.

a. Threatening peer members at collection centers.

b. Switching samples.

c. Reservoir delivery system.

d. Identification card substitution.

APPLICATION/EVALUATION

1. Who has the overall responsibility for the installation drug program?

2. What are the responsibilities of the installation urinalysis test monitor?

3. When is a social evaluation conducted?

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CONCLUSION (.5 MINUTES)

SUMMARY

Summarize the Lesson. Recap The Main Points of the Lesson.

a. Program Evaluation.

b. Air Force Urinalysis Program.

c. Test Monitor responsibilities and major reporting procedures.

REMOTIVATION

Effective program management is the cornerstone of success. Identification of your roles, responsibilities and application of effective management techniques will insure your success in the Social Actions career field. You have just completed a unit of instruction containing specific management oriented objectives, the application of the techniques is your responsibility. You will use this information to evaluate your program and determine which direction to exert effort. The urinalysis information will help you educate, rehabilitate, and advise the commander.

CLOSURE

1. Urinalysis program management is the responsibility of the SA but constructive SAO monitoring will help guarantee an effective program. Remember, you are the overall drug/alcohol abuse Control Program manager for the senior installation commander.

2. Good program evaluation is the only means of effectively validating your program.

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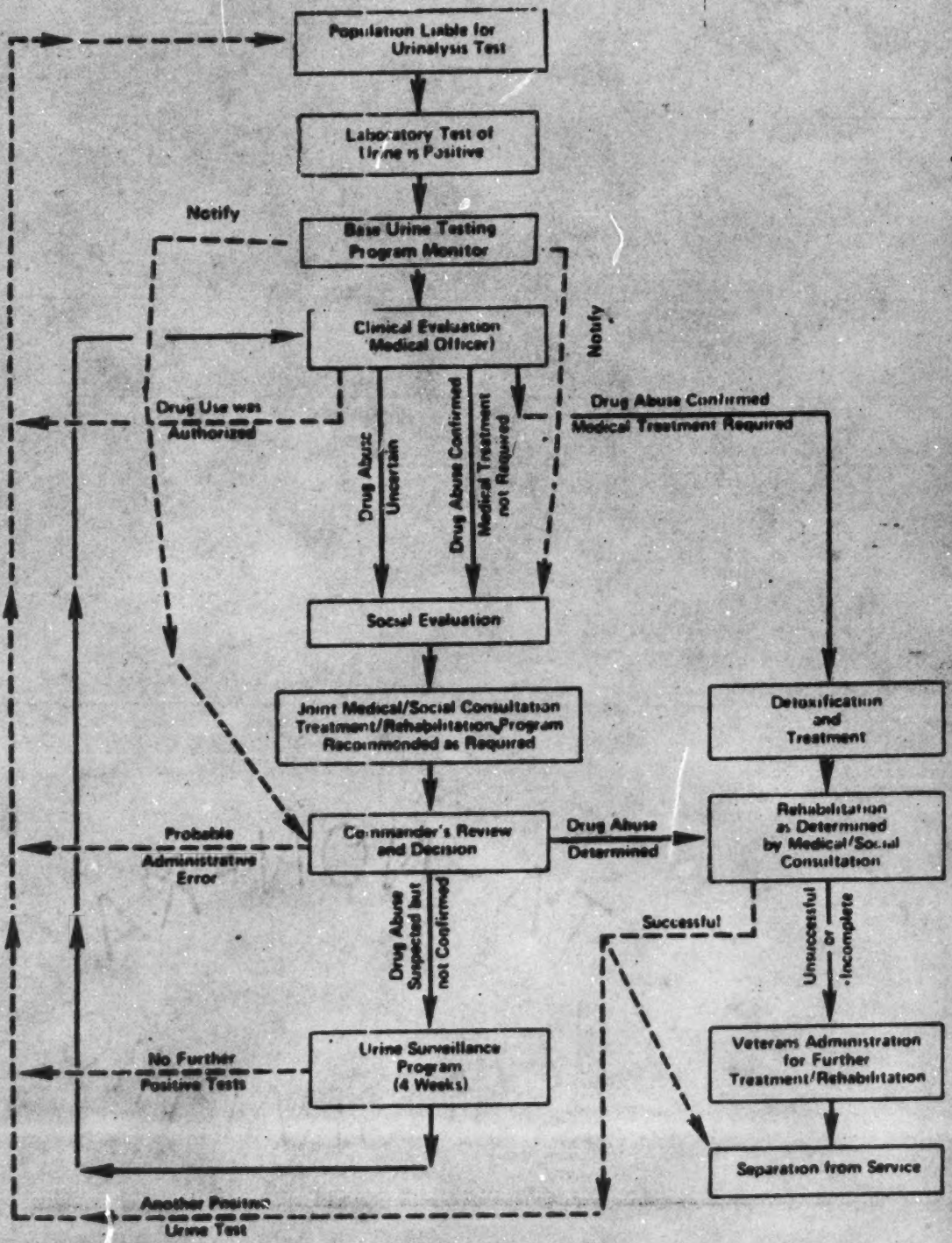
FLOW CHART OF CONFIRMATION PROCEDURES


Population Liable for Urinalysis Test
Laboratory Test of Urine is Positive
Notify
Base Urine Testing Program Monitor
Clinical Evaluation (Medical Officer)
Notify
Drug Use was Authorized
Drug Abuse Uncertain
Drug Abuse Confirmed Medical Treatment not Required
Drug Abuse Confirmed Medical Treatment Required
Social Evaluation
Joint Medical/Social Consultation Treatment/Rehabilitation Program Recommended as Required
Detoxification and Treatment
Probable Administrative Error
Commander's Review and Decision
Drug Abuse Determined
Rehabilitation as Determined by Medical/Social Consultation
Successful
Unsuccessful or Incomplete
Drug Abuse Suspected but not Confirmed
No Further Positive Tests
Urine Surveillance Program (4 Weeks)
Veterans Administration for Further Treatment/Rehabilitation
Separation from Service
Another Positive Urine Test

ATTACHMENT 1

L3ALR73430B/30LR7361B/30ZR7364B

LP BB-IV-1.8
BASE DRUG/ALCOHOL PROGRAM MANAGEMENT
(DRUG ANALYSIS)

PART II - TEACHING GUIDE

INTRODUCTION (5 Min)

ATTENTION

Suppose for a moment that your unit was directed to undergo urinalysis (UA) testing or that you were stopped by Security Police and asked to submit to a breath test. In both instances, you would be providing a specimen sample from your body, which would be analyzed for the presence of either drugs or alcohol, respectively. Positive test results in either case can have significant, far reaching consequence. Clients often want to deny the validity of such test results. How much do you know, or for that matter, what should you know about drug and alcohol (D/A) analysis testing?

MOTIVATION

Although Social Actions has no direct responsibilities for the task functioning of either the UA testing program or the Security Police's alcohol breach analysis testing, it often becomes significantly involved with the end result of such testing. Social Actions role begins when an individual, identified as a D/A abuser by a positive test result, is referred to them for evaluation and counseling. In order to effectively deal with the human aspects of Drug/Alcohol analysis (i.e., the identified abuser), Social Actions personnel must understand the fundamental, technical aspects underlying such analysis. This knowledge will help you deal with client and commander questions of validity which often arise.

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OVERVIEW

1. Cover the lesson objective with the class.

2. Develop the teaching steps chronologically.

a. Drug analysis

(1) Requirements

(2) Limitations

(3) Methods

b. Alcohol breath analysis

(1) Forms and instrumentation.

(2) Fundamental basis and influencing factors.

(3) Basic laws.

BODY (40 Min)

PRESENTATION

1. CRITERION OBJECTIVE: Identify procedures used to determine whether, and to what extent, drugs or alcohol are being used by an individual.

1. Six requirements, two limitations, and three methods of drug analysis.

a. Discuss the six requirements for a drug analysis function.

(1) Reliability

(a) Refers to the degree of accuracy of the test result and consistency of that accuracy.

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(b) False-positives

(c) False-negatives

(2) Convenience

(a) Refers to the time and effort required to carry-out a testing procedure.

(b) Automated testing.

(c) Manual testing.

(3) Economy

(a) Refers to the actual cost per test result.

(b) Cost is closely aligned to the volume of testing and the time required per test.

(4) Specificity

(a) Refers to the degree to which a test procedure can differentiate between closely related drugs.

(b) Entails qualitative discrimination based on chemical and physical properties associated with molecular structure.

(5) Sensitivity

(a) Refers to the ability of a test procedure to detect certain minimal concentrations of drug.

(b) Concentration of drug in a sample is effected by adulteration, dilution, and latency of administration.

(6) Sample

(a) Source of the test sample can vary.

(b) Certain sample sources are better than others for particular testing procedures.

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EVALUATION

1. What are the six requirements of a drug analysis function?

2. What is the difference between specificity and sensitivity?

TRANSITION

b. Discuss the two limitations imposed on a drug analysis function.

(1) Cross-reactivity

(a) Refers to the ability of a drug to interfere with the analysis reaction.

(b) Contributes to a low degree of test reliability.

(c) Lesser the specificity of a test, the greater the cross-reactivity.

(2) Methods

(a) Theoratically, any drug can be tested for an appropriate method.

(b) Desired method characteristics include:

1 Qualitation

2 Quantitation

3 Specificity

4 Sensitivity

5 Adapatability

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EVALUATION

1. What is meant by cross-reactivity?

2. What characteristic would an ideal test method have?

TRANSITION

c. Describe three methods used in drug analysis functions.

(1) Immunoassay

(a) Involves immunologic principles of antibody-antigen interactions.

(b) Types of this method include:

1 FRAT

2 EMIT

3 RIA

4 HI

(2) Chromatography

(a) Involves the separation of individual drugs from a mixture.

(b) Types of this method includes:

1 TLC

2 GC

3 LC

(3) Spectrophotometry

(a) Involves the drug's ability to absorb or emit spectra of light.

(b) Types of this method include:

1 Spectrofluorometry

2 UV-VIS-IR Spectrometry.

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3 Atomic absorption Spectrophotometry.

4 Mass spectometry.

EVALUATION

1. Which method is more specific for identifying different drugs?

2. Which of the three methods is more sensitive in its ability to detect minimal concentrations of drug in sample.

TRANSITION

2. Two forms, instrumentation, fundamental basis, three influencing factors, and three basic laws affecting alcohol breath analysis.

a. Describe the forms of breath analysis and the instrumentation used.

(1) Screening breath analysis.

(a) Used for qualitative detection of alcohol at, below, or above a set critical BAC limit, (i.e., 1%).

(b) Low degree of reliability.

(c) Two types of instrumentation are used in screening.

1 Chemical reagent devices.

2 Electromechanical devices.

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(2) Evidential breath analysis.

(a) Used to specifically detect alcohol and quantitate the amount present.

(b) High degree of reliability.

(c) Two types of instrumentation are used.

1 Chromatographic devices.

2 Spectrophotographic devices.

EVALUATION

1. What are the two forms of a alcohol breath analysis? Which has the highest reliability?

2. Chemical reagent devices are used for which form of breath analysis?

TRANSITION

b. Discuss the fundamental basis for breath analysis and the three factors influencing test results.

(1) The alcohol equilibrium between blood and breath in a fixed ratio of 1 to 2100, provides the fundamental physiological basis for alcohol breath analysis.

(2) Three physiological factors may influence the accuracy of a breath analysis test result.

(a) Plumonary functional capacity.

(b) Body temperature.

(c) Alcohol processing in the body.

EVALUATION

1. What is the fundamental physiological basis for breath analysis?

2. What are the three factors influencing analysis results?

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TRANSITION

c. Explain the three basic laws governing alcohol breath analysis?

(1) Implied Consent Law.

(a) Applicable in all 50 states.

(b) Individuals' consent is implied through their obtaining a drivers license.

(c) Provides the basic authority for states to employ alcohol breath analysis in their traffic law enforcement.

(2) Illegal Per Se Law.

(a) Not applicable in all states.

(b) Makes it a violation of the law to drive with a BAC over a specified limit.

(c) Derived out of the trend to define alcohol-related traffic offenses in terms of BAC.

(3) Pre-Arrest Screening Law.

(a) Not applicable in all states.

(b) Allows for the roadside screening of drivers for the purpose of determining BAC.

EVALUATION

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1. In your own words, what are the three basic lasw governing alcohol breath analysis?

2. Which law makes it an unlawful violation to drive with a BAC over a specific limit?

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3. Which of the three basic laws is applicable in all 50 states?

CONCLUSION (5 Min)

SUMMARY

In this presentation, we have discussed the following:

a. Drug analysis

(1) Requirements

(2) Limitations

(3) Methods

b. Alcohol breath analysis

(1) Forms and instrumentation.

(2) Fundamental basis and influencing factors.

(3) Basic laws

REMOTIVATION

In order for Social Actions personnel to fully understand and effectively deal with the human aspects of D/A analysis, they must have a working awareness of the technical aspects involved. The evaluation and conseling of identified D/A abusers does not take place in a vacuum.

Both the human and technical aspects merge together creating complications, which must be sorted out and resolved by the D/A specialist. When your clients or unit commanders have questions about urinalysis/breath-analysis validity, the information presented today will assist you in answering their questions.

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CLOSURE

The technology of D/A analysis is limited in its reliability only to the extent of individual human physiological variations.

REFERENCES

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PART II - Teaching Guide

INTRODUCTION (5 Minutes)

ATTENTION

1. While some of your clients may suffer the effects of UCMJ actions, all clients will be effected by certain personnel dispositions. These personnel/administrative dispositions can have serious effects on client progress.

2. The personal data contained about drug and alcohol rehabilitees in the personnel data system are very sensitive. If the Advanced Personnel Data System is improperly managed, it could destroy your program credibility.

MOTIVATION

1. You, as a drug/alcohol abuse control specialist should thoroughly understand the implications of personnel dispositions so that you can insure that your client's rights are not abused, and that these personnel dispositions have a positive and motivating force, rather than a demotivating effect on rehabilitation.

2. It will be your responsibility, as part of the rehabilitation committee, to advise commanders on the most appropriate disposition of your clients. Therefore, it behoves you to thoroughly understand the various types of administrative actions that can happen to your clients.

3. There are two offices that can help you manage the rehabilitation and education program, the CBPO and the Management Analysis Office. They will help make your job easier.

4. Finally, the Personnel Data System codes are very sensitive, and must be

accurate. Not only will inspectors be checking to insure their correctness, but also, if the codes fall into the wrong hands they can destroy the credibility of your rehabilitation program.

OVERVIEW

1. Cover the lesson objectives with the class.

2. Develop the lesson chronology.

a. Six administrative dispositions:

(1) Line-of-duty.
(2) Security.
(3) Human Reliability
(4) Unfavorable information file.
(5) Control rosters
(6) Flying status.

b. Two Data Management Systems that can assist you.

c. Drug/alcohol data elements.

TRANSITION

To start things off, let's look at the different administrative dispositions for drug/alcohol abusers.

BODY (2 Hours 40 Minutes)

PRESENTATION

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1y. CRITERION OBJECTIVE: Identify the appropriate drug/alcohol abuser disposition requirements with respect to the following: (1) Line-of-duty (LOD) determination and investigation:

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(2) security limitations; (3) disqualification under the Human Reliability program; (4) unfavorable information files (UIFs); (5) control rosters; and (6) flying status.

1. Discuss LOD Determination and Investigation:

(a) Discuss general information about LOD.

(1) Explain LOD determination, which is used to determine:

(a) Forfeiture of pay because of absence from duty (37 United States Code (USC) 802).

(b) Eligibility for physical disability or retirement.

(c) Lost time required to be made good (10 USC 972).

(2) Discuss when a LOD investigation is required.

(a) A LOD determination is required when an individual's illness or desease is treated by a physician which results in any of the following:

1. Inability to perform duties for more than one day (24 hours).

2. Possibility of liability or permanent disability or future claim against the Government.

(3) Discuss procedures for LOD investigation

(a) All LOD determinations are "in the line of duty" unless.

1 The disease/ injury resulted from the person's own misconduct.

2 Occurred while in desertion status.

3 Occurred while absent without authority.

4 Existed prior to service.

(b) There are basically three methods of making LOD determinations.

1 Administrative determination and entry in the medical records for minor injuries or diseases which obviously were contracted in the line of duty or existed prior to entering the service maybe made by the phisician. The LOD status for any disease of natural origin is determine soley by the medical officer.

2 An informal investigation is initiated when an injury could be permanently disabling and was incurred in the line of duty.

(c) Appointing authority reviews case and makes approval action.

b. Discuss Drug and alcohol implications in LOD determinations.

(1) Drugs

(a) Any disease resulting from intemperate (unauthorized, willfull) use of marijuana, narcotics, or dangerous drugs is regarded as "due absence from duty due to withdrawal.

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(b) Necessary hospitalization for evaluation before drug treatment and rehabilitation programs for which the member has volunteered will not be considered to be as incident to drug abuse, per se, and, therefore, will not require and LOD determination.

(2) Alcohol

(a) Any organic, chronic disease which is a secondary result of chronic or intemperate use of a alcohol is considered "in line of duty." (AFR 35-67 Sec B). This includes cirrhosis, fatty metamorphasis, and chronic brain syndrome.

(b) Acute transient disease/condition directly caused by intemperate (excessive) use of alcohol is due to misconduct.

(c) Injuries resulting from intemperate use of alcohol are considered "Due to misconduct".

(d) However, drinking, drunkenness, and alcoholism are, in and of themselves, not the subject for LOD determination.

2. Discuss security limitations.

a. discuss general information about security limitations:

(1) Distinguish between security clearance, access to classified information, and unescorted entry to restricted areas.

(a) Security clearances involve investigating a person to insure he or she is reliable enough for individual access to classified/sensitive information.

(b) Access to classified information is authorized by the unit commander when the security clearance indicates that the individual concerned is eligible should his/her official duties require a need to know classified information.

(c) Unescorted entry to restricted areas may be authorized for persons with a valid security clearance and the need to perform duties in restricted areas.

(2) Identify procedures in making security determinations.

(a) Unit commander makes individual determinations on all available information.

(b) Commander may temporarily suspend access/unescorted entry when questionable events occur.

b. Discuss drug and alcohol implications in security determinations.

(1) Drugs

(a) Explain that security determinations are made according to the type of drug abused, the risk involved in the duty, and the category of the drug abuser. (REF: AFR 205-32, Atch 9)

(b) Substantiated inservice drug abuse may be used as the basis for suspension or denial of a security clearance or unescorted entry while an individual is in the drug rehabilitation program.

(c) Experimentation or use will not be used as the sole basis for suspension, denial, or revocation of clearances, or unescorted entry of the individual as in phase V of the drug rehabilitaiion program.

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(d) LSD experimenters must have completed phase V and one year must have passed since the last injection of LSD before security clearance/unescorted entry is authorized.

(e) Drug addicts and suppliers will not be granted a security clearance or authorized unescorted entry and they are usually discharged from the Air Force.

(2) Alcohol

(a) A history of alcoholism is not grounds for permanent disqualification for security clearance, access to classified information, or unescorted entry to restricted areas.

(b) Habitual excessive drinkers and alcohol addicts, after identification or diagnosis of alcoholism, are not generally granted access to classified information or unescorted entry to restricted areas.

(c) Unit commanders will obtain a medical recommendation regarding security clearance or access authorization, after the necessary medical treatment is completed.

(d) These recommendations, together with the member's demonstrated reliable duty performance, are the basis for a security clearance or access authorization.

(e) Recovered alcoholics who have demonstrated their sobriety and are otherwise qualified for unrestricted duty worldwide will be assigned to the same duties as other members having similar qualifications.

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3. Discuss the Human Reliability Program (HRP)

a. Discuss general information concerning HRP.

(1) The Human Reliability Program (HRP) is designed to insure:

(a) that personnel selected for high-risk assignments are trustworthy, emotionally sound, loyal, reliable, and exercise good judgement and professional competence.

(b) the highest possible standard of individual reliability in personnel performing duties associated with nuclear weapons or nuclear weapons systems.

(c) HRP covers specific AFSCs as well as certain duty positions involving nuclear weapons or other high-risk areas.

(2) Identify HRP procedures

(a) Unit commander must make the determination in HRP disqualifications based on the individual's stability and reliability.

(b) Individuals may be disqualified under HRP for problems such as:

1. financial irresponsibility.
2. lack of motivation.
3. adverse involvment with civil law authorities.
4. martial/psychological difficulties.
5. control roster actions.

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6. courts-martial charges.

(c) Temporary disqualification normally should not exceed 6 months: and individuals should be assigned to non-HRP duties. permanent disqualification occurs in more serious or chronic cases.

(d) Reinstatement is initiated by the immediate commander if:

1 the cause of disqualification has been resolved, and the disqualification was temporary.

2 "successful completion of drug/alcohol rehabilitation if abstinence can be established, and the member is recommened for reinstatement by appropriate staff agencies." (REF AFR 35-99, CH 5); and the disqualification was temporary.

3 Member is under involuntary administrative separation under AFM 39-10, if the reason for discharge did not involve misconduct or did not reflect adversely or individual reliability.

b. Discuss drug and alcohol implications in HRP.

(1) Drug.

(a) Individuals may be disqualified for:

1 drug abuse as defined in AFR 30-2, or entry in the Drug Rehab Program, even if through LPCP.

(b) If the drug is LSD, disqualification will be permanent.

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(2) Alcohol

(a) individuals may depending on the unit commander's decision based on rehab committee recommendations be disqualified for:

1. overindulgence in alcohol.

2. medical conditions associated with alcoholism.

3. psychological conditions associated with alcoholism.

4. Discuss UIFs.

a. Discuss general information about UIF.

(1) Identify the meaning of a UIF. These files provide a repository for substantiated derogatory information concerning an Air Force member's personal conduct, duty, performance, judicial actions, etc., against the individual.

(2) Identify UIF procedures

(a) UIFs are initiated by the unit commander in accordance with procedures outlined in AFR 35-32.

(b) Information is sent to Special Actions (DPMQA)

(c) Information is then summarized on the AF Form 1137 by DPMQA.

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(d) Unit commanders are required to review UIF quarterly.

(3) UIFs may contain;

(a) court-martial action.
(b) article 15 actions.
(c) letters of counseling.
(d) lettere of counseling.

(4) Discuss UIF dispositions.

(a) UIFs are normally destroyed one year from the date of the last entry.

(b) Article 15, court-martial and civil court convictions are retained for two years from date of punishment.

(c) UIFs are destroyed upon reenlistment of separation.

b. Discuss drug and alcohol implications in UIF.

(1) Drug

(a) all 1612 initiates a UIF (including LPCP).

(b) 1612s are stored in UIF.

(c) any article 15 or court-martial initiates UIF.

(2) Alcohol

(a) UIFs are not initiated on the basis of alcohol abuse or alcoholism alone, unless they result in misconduct or substandard performance or other related reasons.

(b) AF Forms 1611 are not stored in UIF but returned to case file.

5. Discuss control rosters.

a. Discuss general information about control rosters.

(1) Control rosters contain the names of personnel whose conduct are performance requires special observation. The intention of the control roster is to place a person under special observation in hopes of rehabilitating that person.

(2) Identify control roster procedures.

(a) Control rosters are initiated by the unit commander in accordance with procedures outlined in AFR 35-32.

(b) Control-roster action is a ninety-day minimum, with increments not to exceed 270 days.

(c) A name may be removed from the control roster early if the original reason for the action proves invalid. This is the only way.

b. Discuss drug and alcohol implications.

(1) Drugs

(a) Drug abuse may be the basis for control roster action.

(b) LPCP participants are normally not subject to control-roster action.

(c) Secondary effects of drug abuse may result in control roster action.

(2) Alcohol

(a) Alcohol abuse or alcoholism alone cannot be the basis for control-roster action.

(b) Substandard duty performance could be the basis for control roster action.

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6. Discuss personnel on flying status

a. Discuss general information about flying status.

(2) Discuss procedures in flying status suspension.

(a) Personnel on flying status are required to have annual flight physicals and review.

(b) If Tactical unit commander or physician discovers any problems the individual may be temporarily or permanently removed from flying status.

b. Discuss drug and alcohol implications.

(1) Drugs

(a) If drug abuse is substantiated, the suspension remains in effect until the person has successfully completed rehabilitation, is recommended for return to flying duties by the Rehabilitation Committee, and is medically certified acceptable for flying duty. The person submits a request through channels to the major command. If the request is approved, the major command will publish aeronautical orders. (IAW AFR 35-13)

(b) Explain that suspension is permanent if a hallucinogenic drug which causes flashbacks is involved.

(2) Alcohol

(a) If alcoholism/ chronic alcohol abuse is substantiated, the suspension remains in effect a minimum of 60 days of non-flying duty in the follow-on support phase of rehabilitation.

(b) In the case problem drinkers, unit commanders may choose

to allow them to remain on flying status if they appear sufficiently reliable for flying duties.

EVALUATION

1. What is the restriction on establishing a UIF on an alcohol abuser?

2. May an LSD user be granted access to classified information?

3. What are two reasons for disqualification under the Human Reliability Program.

4. When may a name be removed from, a control roster?

PRESENTATION

1z. CRITERION OBJECTIVE: Identify two management resources and how each assists in the management of the drug and alcohol rehabilitation program.

1. Explain that the CBPO/personnel system manager (PSM) is the OPR for the Advanced Personnel Data System (APDS).

a. THE CBPO:

(1) Provides APDS inquiry service.

(2) Constructs Direct English Statement Information Retrieval (DESIRE) inquires which retrieve information from the computer storing personnel data.

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(3) Maintains the APDS.

b. The CBPO/special actions unit assists in the management of the drug/alcohol rehabilitation program by providing special actions APDS inquiries,

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in coordination with the PSM. The PSM also provides rosters on request, such as education attendance listings. Inquiries are individual or group.

(1) Group inquiries include:

(a) Name listings (by race, ethnic group, etc.).

(b) Matrix (for example, by Air Force specialty code (AFCS) or other codes).

(2) Individual inquiries.

(a) Personal information on any Air Force member (categorized FOR OFFICIAL USE ONLY): e.g., marital status and date of rank.

(b) Report individual person (RIP) (shell on individual members — personal information).

2. Explain that the management analysis office assists in the management of the program by providing the following services.

a. Collects raw data statistics from base organizations.

b. Integrates and interprets data in an organized format.

c. Supplies data to staff agencies for planning, organizing, and managing purposes.

d. Informs commanders of base status.

e. Integrates all agencies, projections, and probable cause of deviations.

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f. Refers information to base OPR agencies.

g. Maintains summary files on special studies.

h. Maintains data bank of programs and resource statistics.

i. Provides graphic services.

EVALUATION

1. What are the services provided by the CBOP PSM? The special actions unit?

2. What is a group inquiry?

3. What is a RIP?

4. How may management analysis assist Social Actions?

PRESENTATION

1aa. CRITERION OBJECTIVE: Identify the drug and alcohol data elements of the Advanced Personnel Data System (APDS) and the general procedures for managing data inputs.

1. Explain that the data element UNFAVOR-INFO-ID (Unfavorable Information Identifier) is a "yer-or-no" indicator as to whether or not an individual has a UIF.

a. Element is entered by CBPO, based on the establishment of a UIF by the commander.

b. The UIF if summarized on AF Form 1137, Unfavorable Information File Summary, by DPMQA based on information received from unit commanders.

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c. The UIF disposition (destruction) date (UNFAV-INFO-DISP-DATE) (Unfavorable Information Dispisition Date) is also coded for one year after the last UIF entry.

2. Explain that the data element SUBS-AB-CNTL-ID (Substance Abuse Control Identifier) indicates the type of drug and the category of the user.

a. This two-place code reports all drug and alcohol abusers by type of drug and category of abuse.

b. Commanders code this on the AF Form 1611, Notification of Alcohol Abuse Information, and AF Form 1612. Notification of Drug Abuse Information.

c. Monitoring is the responsibility of the Social Actions office to insure accuracy and timely input.

d. Input into the APDS is the CBPO/special actions unit responsibility.

e. For example, a major marijuana supplier would receive a code of "A6."

f. Social Action must check printouts monthly to verify the system for accuracy. These Data will be used for the HAF 7111 report.

3. Explain that the date element SUBS-AB-CNTL-SOURCE (Substance Abuse Control Source) indicates the sources of identification.

a. Element is provided to CBPO by the commander on AF Form 1611 or 1612.

b. Social Actions has verification-ing responsibilities.

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4. Explain that SUBS-AB-TREAT-LOC (Substance Abuse Treatment Location) ode is a one-letter code which indicates the location rehabilitees receive treatment/rehabilitation.

a. SL must insure that all rehabilitees who complete central treatment are properly accounted for in the APDS.

b. If rehabilitees receive treatment at any one of the central Alcohol Treatment Centers, then SL annotates the SUBS-AB-TREAT-LOC code for that center in the remarks section of AF Form 1611.

c. If the client receives only local rehabilitation, then code "B", Base of Local Treatment, is entered in the remarks section of AF Forms 1611 and 1612.

5. Explain that RACE-REL-TNG-YR-MO and SUBS-AB-TNG-YR-MO indicate Human (Race Relations Training, Year/Month, and Substance Abuse Training, Year/Month).

a. Data elements record training.

b. Reporting is the responsibility of the Social Actions office. Often, card decks are used to indicate who has attended.

c. The OPR for TNG Code input into the APDS is the CBPO/PSM.

6. Explain the routing and verification procedures of the substance about codes and AF Forms 1611 and 1612.

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a. AF Form 1612, Notification of Drug Abuse Information:

(1) Unit commanders must initiate the AF Form 1612, on the date

of identification of a member as a substantiated drug abuser, if identification is not yet substantiated, complete Section I. If identification is substantiated, complete section II. In completing Section II, the unit commander will indicate the predominant drug of abuse and the level of abuse as defined above, after consulting with the rehabilitation committee if necessary. The unit commander will make an appointment for the member's social actions intake interview. They do not initiate AF Form 1612 for members considered for, but not entered into, rehabilitation, per paragraphs 4-20B and c.

(2) AF Form 1612 will be prepared by the unit commander in an original and four copies. Distribute as follows:

(a) Original, copy one and copy two are forwarded to the Social Actions Office.

(b) Copy three is given to the member identified thereon and serves as official notification of entry into the rehabilitation program.

(c) Copy four is retained by the unit commander for suspense of follow-up actions, or destroyed if no further actions are required.

(3) The social actions office, drug and alcohol abuse control officer or NCO, will complete the following on receipt of AF Forms 1611 and 1612 from the unit commander:

(a) Review the form and annotate the appropriate APDS coding in Section II for substantiated drug abusers, and add the treatment location code.

(b) Initial coordination record and forward copy one of the AF 1612 to CBPO/DPMQA.

(c) Initiate the member's rehabilitation case file and place the original AF Form 1612 in it.

(d) Forward copy two to the medical service personnel for information is the evaluation process and for use by the urinalysis testing program monitor. Copy two will not be filed in the member's medical records.

(4) The CBPO/DPMQA personnel will use copy one to initiate appropriate APDS and other personnel actions. File copy one of AF Form 1612 in the member's UIF folder after all required personnel actions are completed.

(5) If the unit commander determines that a member's identification and entry into the rehabilitation program was in error, he or she will complete Section III on a new AF Form 1612. Justify in the remarks block the removal from the rehabilitation program. Prepare and distribute two copies of the form as follows:

(a) The original copy to the social actions office. The drug and alcohol officer of NCO will coordinate and forward it to CBPO/DPMQA for appropriate action to remove APDS codes and other personnel data entries. The case file will be destroyed at this time.

(b) Copy will be given to the member as official notification of removal from rehabilitation.

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(6) When a member has successfully completed the rehabilitation program, the unit commander will initiate a new AF Form 1612, complete section III, and process it in accordance with paragraph c(1) through (3).

(a) AF Form 1611, notification of Alcohol Abuse Information, are outlined above. EXCEPTION: Receipt of AF FOrm 1611 by the CBPO will not result in the automatic establishment of an Unfavorable Information File (UIF), which requires a separate action by the unit of commander. UIF action will be based on substandard duty performance or misconduct, and not soley on entry into rehabilitation or on alcohol abuse. When A UIF is not established, the CBPO will return the AF FOrm 1611 to social actions for the member's case file after the completion of abuse data

(b) Social actions personnel will request a computer printout each month from CBPO/DPMQA. This printout will list all individuals identified in APDS with a Substance Abuse Control Identifier (SUBS-AB-CNTL-ID) and will be used for the proper management of the rehabilitation program. The SUBS-AB-TREAT-LOC code along with the source and identification codes will be used to automate the HAF 7111 Report. It is, therefore, essential that the data contained in the APDS be accurate.

(c) The CBPO/DPMQA will establish internal control procedures to prevent unauthorized personnel from having access to APDS code. Access to substance abuse control data is limited to personnel and functions listed in figure 4-6 as Social Actions should insure these procedures are working in order to maintain a credible program.

(d) Social actions must establish internal suspense procedures and insure that substance abuse codes are properly removed from the active APDS after a member completes the program - This can be accomplished by:

(1) Monthly printout monitoring.

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(2) Correct & return roster to CBPO for update.

(3) Reverify with next printout.

(CONCLUSION (5 Minutes)

SUMMARY

We have covered the following major points:

a. Admininstrative dispositions.

(1) Line-of-duty determination and investigation.

(2) Security limitations and disqualification under the Human Reliability and Personal Reliability Programs.

(3) Unfavorable information files.

(4) Control rosters.

(5) Flying status.

b. Data management systems

c. Data elements of the Advanced Personnel Data System.

REMOTIVATION

These are just a few of the administrative actions which affect drug/alcohol abusers. If you will keep current with the apporpriate revisions and changes to directives, your job as a rehabilitation manager will be much easier. These directives will have a definite impact on your clients and your base-level rehabilitation program.

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CLOSURE

Thank you for your attention and participation.

ASSIGNMENT

Give complementary technical training assignment, when appropriate.

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LP-BB-IV-1.9

BASE DRUG/ALCOHOL PROGRAM MANAGEMENT
(REPORTS)

PART II - TEACHING GUIDE
INTRODUCTION (5 Minutes)

ATTENTION

1. Reports influence the decisions which affect your budget, manpower authorizations and the policies under which we operate.

2. Reports can be tedious to prepare, unless you know the shortcuts. If incorrectly prepared, they can cause problems with your drug officer, chief of social actions senior installation commander, or MajCom.

3. Reports that are not submitted when required will cost your office's reputation, and may result in the downgrading of performance/efficiency reports.

MOTIVATION

1. Reports serve the following functions:

a. They keep higher headquarters and commanders informed.

b. Serve to gain support for your programs.

c. Help coordinate policy/procedure action and give feedback on implemented policy, and

d. Help you organize your thoughts in such a way that you can gain as to what has been done, and see what still needs to be accomplished.

OVERVIEW

1. Today, we'll be discussing the report most dreaded, yet most needed and beneficial to the RCS: HAF (DPX) 7111 report which is accomplished on AF Form 3017.

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2. In the 7111 report, you'll find that there are certain short cuts, and ways to verify whether your statistics are correct. Proper checking will prevent embarrassment, and will aid you in passing the performance Criterion objective in the Administrative Practicum where your group will be asked to complete a quarterly 7111 report.

TRANSITION

Let's examine the 7111 report in more detail.

BODY (40 Minutes)

PRESENTATION

1bb. CRITERION OBJECTIVE: Identify the correct procedure for completing AF Form 3017, Drug/Alcohol Abuse Control report.

1. Explain that AF Form 3017 management tool which:

a. Provides HQ USAF and major commands (MAJCOMs) with data necessary for overall command and Air Force policy-making and management.

b. Reveals Air Force trends on drug use, cost analysis, etc.

c. Provides data for input to the Department of Defense (DOD), other Governmental agencies, and (most importantly) Congress for continued financial support.

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2. Demonstrate the result of the HAF 7111 Report using HO-B-IV-1-4, USAF Statistical Summary. Give examples of

how it may be used to make decisions in the following areas:

a. Money,
b. Manpower,
c. Policy.

3. Discuss Major Section I - Local Drug/Alcohol Abuse Control Program Status.

a. Discuss Subsection A - Prevention.

(1) This is prepared from class attendance records for the reporting period.

(2) This is a cumulative figure for the calendar year.

b. Discuss Subsection B - Identification.

(1) This section of the report has caused problems to some bases because of the misinterpretation of the word "identified personnel on your base, not permanent-change-of-station (PCS) personnel being transferred to your program."

(2) Again, as throughout all of Section B-1 number of abusers identified refers to only those identified on your base during the reporting period. Do not include PCS transfers on this line.

(3) Insure that all Air Force specialty codes (AFSCs) that are indicated appear in Air Force Manuals (AFMs) 36-1 and 39-1.

(4) Items 4 through 9 are self-explanatory.

c. Discuss Subsection C - Rehabilitation. This section is the area of the report which has presented the most problems for all bases at one time or another. We hope the following guidelines and checklist will aid you in the preparation of your RCS-Q-HAF-3711 Report (AF Form 3017).

(1) Discuss Item 1 - Phase I - IV Status (Drug Abuse).

(a) Subsection A - New Identification. These figures are obtained from, and will be in agreement with, Section B-1 totals. (Checkpoint) NOTE: These figures will not include PCS gains during the reporting period.

(b) Subsection B - PCS Gains - Phase I - IV. At this point in the report, indicate PCS gains. PCS gains in Phase V are not indicated on this line.

(c) Subsection C - Entered Phase V. Indicate those individuals in your program who have entered Phase V during the reporting period. This is not to include those who were PCS gains to Phase V.

(d) Subsections D through J are self-explanatory.

(2) Discuss Item 2 - Phase V Status (Drug Abuse).

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(a) Subsection A - Entrants from Phase I - IV. These figures must agree with figures on line C-1 (Entered Phase V). (Checkpoint).

(b) Subsection B - PCS gains in Phase V. At this point, indicate PCS gains in Phase V.

(c) Subsections C through I are self-explanatory.

(3) Discuss Item 3 - Program Summary (Drug Abuse) Phases I - IV.

(a) Subsection A - Number at End of Previous Quarter. This information is obtained from your previous report, indicating number remaining in Phase I-IV, line 3-E, total remaining in local rehabilitation by Phase. NOTE: This does not include Phase V.

(b) Subsection B - Number Entering During This Reporting Period. This information is obtained from Section I, C1 (a plus b).

(c) Subsection C - Total Participants for the quarter. Add 3-A and B for this information.

(d) Subsection D - Number Exiting During This Reporting Period. This information is obtained from Section I, C2 (c through J). (Checkpoint).

(e) Subsection E - Number Remaining in Local Rehabilitation by Phase. This is obtained by subtracting Line 3-D from 3-C. This total is then broken out by Phases I-IV. (These figures should agree with the number of case files and personnel you have in each phase at the end of the reporting period).

(4) Discuss Item 4 - Program Summary (Drug Abuse) Phase V.

(a) Subsection A - Number at End of Previous Quarter. This information is obtained from your previous report. Section I, C4e. (Checkpoint).

(b) Subsection B- Number Entering During This Reporting Period. This information is obtained from Section I, C2 (a plus b). (Checkpoint)

(c) Subsection C - Total Participants for the Quarter. This is obtained by adding 4-A and B.

(d) Subsection D - Number Exiting During This Reporting Period. This information is obtained from Section I, C2 (c through i).

(e) Subsection E - Number Remaining in Phase V. Compute the answer by following the formula: a plus b equal c minus d equals e.

(5) Discuss Item 5 - Local Alcohol Rehabilitation Status.

(a) Subsection A - New Identification. These figures will be obtained from, and will be in agreement with, Section I, B2 totals. (Checkpoint) NOTE: These figures will not include PCS gains during the reporting period.

(b) Subsection B - PCS Gains. At this point in the report, indicate PCS gains into rehabilitation. Do not include PCS gains entered into your program in follow-on support status.

(c) Subsection C - Entered Follow-On. Indicate those individuals in your program who have entered follow-on support during the reporting period. This is not to include those who were PCS gains to follow-on support. (See Checklist, 6-B)

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(d) Subsections D through J are self-explanatory.

(6) Discuss Item 6 - Local Alcohol Follow-On Support Status.

(a) Subsection A - Entrants from Local Rehabilitation and Alcohol Treatment Center. The Figures for local rehabilitation should agree with Section I, C5c.

(b) Subsections B through I are self-explanatory.

(7) Program Summary (Alcohol Abuse).

(a) Subsection A - Number in Local Rehabilitation and Follow-On During Reporting Period. This information is obtained from Section I, C7e of your previous report.

(b) Subsection B - Number of New Entrants into Local Rehabilitation and Follow-On During Reporting Period. This information is obtained from Section I, C5 (a plus b) and C6 (a plus b).

(c) Subsection C is self-explanatory.

(d) Number Exiting Local Rehabilitation and Follow-On During Reporting Period. This information is obtained from Section I, C5 (c through j) and C6 (c through i).

(e) Number Remaining. Figure this item by using the following formula: Verify: a plus b equals c minus d equals e.

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(8) Discuss Item 8 - Number of Members Who Were Cross-Trained or Changed AFSC. This section is self-explanatory; however, indicate primary reason(s) for those identified in this section in Additional Remarks, page 6 of 6 of AF Form 3017.

(9) Discuss Item 9 - Number of Members Working Outside Their Specialty Over 90 Days (for example, as permanent bay-orderly, etc.) Effective from Date of Their Identification as Substantiated Drug/Alcohol Abusers. The number identified in this section must agree with the number of entries on page 5 of 6 at the top of the page.

(10) Discuss Item 10 - DAF Civilian Personnel.

(a) Subsection A - Number in Program at Beginning of Period. These figures may be obtained from, and agree with, Item 10D of your previous report. (Checkpoint)

(b) Subsection B - Number Added During Period. This section is self-explanatory.

(c) Subsection C - Total Numbers Exiting Program. Items (1), (2), and (3) will, as a total, equal line 10C.

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(d) Subsection D - Number Remaining in Program at End of Period. These figures are obtained by totaling lines 10A and B, and then subtracting line 10C.

(11) Discuss Item 11, Number of Dependents Counseled by Social Actions Personnel. This item is self-explanatory.

4. Explain that Major Section II - Narrative Summary is self-explanatory.

5. Emphasize that Major Section III - Alcohol Treatment Centers will not be prepared at base level Social Actions.

APPLICATION/EVALUATION

1. Have students follow through the AF 3017 as you explain each step in the procedure.

2. Later, each group will complete the 7111 report during the Administrative practicum.

3. Program Management Quiz, conducted during CTT.

a. Instruct students to remove all books and papers from their desks and distribute Program Management Quiz, B IV-1-5-Q.

b. Permit students 30 minutes to complete the quiz.

c. At the end of 30 minutes, instruct students to exchange papers.

d. Review each question, indicating the correct answer to each.

e. Have students enter the appropriate grade, as instructed.

f. Collect all quizzes during groups the following day and inform students to make sure that their names and group number are entered.

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CONCLUSION (5 Minutes)

SUMMARY

1. We have discussed the procedures for completing the 7111 Report which you'll be applying shortly.

REMOTIVATION

Remember, reports are vital to good decision making - application of the knowledge about verification of your report statistics can save you hours of time in recomputing your 7111 report.

CLOSURE

Thank you for your attention and participation.

ASSIGNMENT

Give complementary technical training assignment, when appropriate.

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3ALR73430B/30LR7361B/30ZR7361B-IV/1.10 BASE DRUG/ALCOHOL PROGRAM MANAGEMENT (ADMINISTRATIVE PRACTICUM)

PART II TEACHING GUIDE

1. Initial Briefing (to be completed as the APPLICATION step of Base Drug/Alcohol Program Management - Responsibilities and Case Files). Inform students that application of the lecture information pertaining to the organization of case files, the completion of Rehabilitation Summaries of Treatment, and the documentation of intake interviews will be accomplished during scheduled complementary technical training (CTT) time and two hours of small group time. Emphasize that Study Guide (SG) B-IV-1-21, Base Drug/Alcohol Program Management, provides a solid review of all the important lecture items.

2. During the Privacy Act and Case Files Lecture, explain to the students that the practicum will be divided into four parts.

a. Case File Organization: Assembly of the documents in Workbook (WB) B-IV-1-13, Base Drug/Alcohol Program Management (one for practice and one for evaluation).

b. Completion of a Rehabilitation Summary of Treatment.

c. "Role-Playing" and documentation of an intake interview with a client concerning drug or alcohol abuse.

d. Completion of AF Form 3017, Drug and Alcohol Abuse Control Report.

3. During the Privacy Act Case Files Lecture refer to the previously distributed WB B-IV-1-13 as indicated in paragraph 1, above. Explain the importance of proper organization and documentation of intake interviews. Also explain that WB B-IV-1-13 contains the following sections.

a. Section I: Unassembled Case File Documents.

b. Section II: Intake Interview Instructions.

c. Section III: Intake Interview Documentation Progress Checklist, HO B-IV-1-19; and Rehabilitation Summary Progress Checklist, HO B-IV-1-18.

d. Section IV: Instructions for Completion of the 7111 Report.

e. Section V: A completed AF Form 3017, Drug/Alcohol Abuse Control Report (a quarterly report for the previous quarter).

f. Section VI: Blank AF Form 3017 (to be completed).

NOTE: HO B-IV-1-23 contains the roles necessary for the intake interview. These HOs are to be used in the portion Program Management Group Application concerning Intake Interviews. Instructors should hand out these roles during the hour allotted and collect them at the end of the instruction period.

(1) Case File Organization. Inform students that most documents in Section I represent a document pertaining to alcohol/drug abuse case files. Tell the students that during the scheduled CTT time they will properly assemble the alcohol case file by separating each document into administrative and counseling information. At the end of the CTT hour, students will submit their practice alcohol case file to the instructor for feedback. When they complete the alcohol case file correctly, they may begin work on their drug case file which they will complete before the first hour of the administrative practicum. After giving feedback to students on their alcohol case file, begin your lecture on the summary of treatment and intake interview. (See the Privacy Act and Case File Lesson Plan, 1.2.)

(2) Rehabilitation Summary of Treatment. Additionally, tell the students that they are to review the documents they have assembled and complete a Rehabilitation Summary of Treatment, based on the information contained in the case file. Inform students that care must be taken in reading the case file contents to insure a correct summary of treatment is developed. This will also be accomplished during scheduled CTT time, in accordance with HO B-IV-1-18 (Attachment 2). Each student will submit the assembled drug case file and completed Drug Rehabilitation Summary of Treatment to his/her group facilitator during the first Administrative Practicum hour, for evaluation.

(3) Intake Interview Session Documentation. During the first Program Management Group hour, collect completed drug case file and Summaries of Treatment from all students.

(a) Introduce the exercise on documentation for intake interview sessions by explaining the importance of proper documentation of counseling sessions.

(b) Direct students into dyads. Each student will select one of the two roles listed in HO B-IV-1-23-I. Inform students that one student in each dyad will role-play a counselee. The other student will conduct and document the counseling session, in key-word outline form, as the counselor. Time for this exercise is twenty-five minutes.

(c) At the end of the first twenty-five minutes direct students to reverse roles, so that the student who was the counselee is now the counselor, and the student who was the counselor is now the counselee. Again, one student in the dyad will simulate the counselee and the other the counselor. However, two students in the same dyad cannot use the same role.

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(d) At the end of the second twenty-five minute period (the second role-playing situation, direct students to document the intake interview session from their outlines, in accordance with the Case File Documentation Progress Checklist. Collect the role sheets, HO B-IV-1-23 when the students are finished role-playing the intake interview. DO NOT allow students to continue sharing information. From this point they must work independently. They will have an hour of CTT, and the second hour of the Administrative Practicum to complete the intake interview documentation. Inform students that the intake interview documentation will be due by the end of the second Administrative Practicum hour. Collect the intake interviews by the end of the second Administrative Practicum hour and begin grading.

(e) Evaluate the submitted Rehabilitation Summaries of Treatment, using HO B-IV-1-18, and the case file organization with an "S" or "U", while the students are in dyads, simulating the role-playing situations.

(f) During the second hour, return the graded case files and Rehabilitation Summaries of Treatment for feedback.

(g) During the third hour, return the graded intake interviews for feedback.

(h) During the fourth hour, grade and give feedback on the group AF Forms 3017 (RCS: HAF/DPX(AR) 7111).

(i) AF Form 3017 (RCS: HAF/DPX(AR) 7111). Explain that the HO IV-1-13 contains a completed AF Form 3017, which represents a report for the first quarter of 1976. The blank AF Form 3017 will be completed as the next quarterly report, using the information from the documentation of the intake interview session practicum.

(1) Completion of the report is a group project to be accomplished during the scheduled CTT time. Instruct students that the senior member of the group will submit the completed report during the last hour of the Administrative Practicum.

(2) Explain that each of the documentations of the intake interview sessions will be considered as a single entry in the report. For example, a group of eight students will have eight new entries, four drug, and four alcohol.

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j. Schedule for these administrative practicum hours are as follows:

HOUR BY HOUR SCHEDULE

CASE FILE LECTURE HOUR	
CTT:	Complete alcohol case file for practice.
CASE FILE GROUP HOUR	Grade practice case files and lecture on summary of treatment, intake interviews and social evaluations.
ADMINISTRATIVE PRACTICUM	
FIRST HOUR	
0000	Introduce exercise, collect case files and rehabilitation summaries of treatment, and divide students into dyads.
0010	Begin first role-playing intake interview. (Instructor begins grading the case files and treatment summaries.)
0030	Begin second role-playing intake interview.
0050	Break
CTT HOUR	Continue documentation.
SECOND HOUR	
0000	Student document the intake interviews individually while the instructor completes grading of the case files and rehabilitation summaries of treatment.
0030	Instructors return graded case files and rehabilitation summaries of treatment and discuss them with the students. Instructors should arrange counseling with those who have failed to pass the criterion objectives.
0050	Break
THIRD HOUR	
0000	Instructors return graded intake interviews and provide feedback. Arrange counseling with those who failed to pass this criterion objective. Any additional time may be spent on beginning the group's AF Form 3017.
0050	Break
FOURTH HOUR	
0000	Instructors collect, grade, and give feedback on the group-prepared AF Form 3017 (RCS: HAF/DPX(AR) 7111 Report). Additional time may be spent on clearing up any Base Drug/Alcohol Program Management question students may have in preparation for the Block IV written measurement.

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Social Actions Training Branch
Lackland Air Force Base, Texas 78236

HO 30LR73430B/30LR7361B/
30ZR7364B-IV-1-18-C
27 April 1976

REHABILITATION SUMMARY PROGRESS CHECKLIST

STUDENT NAME _____ INSTRUCTOR _____

GROUP # _____ DATE _____

ELEMEMENTS FOR SUMMARY OF REHABILITATION TREATMENT

	S	NI	U	Comments
1. Identifying Data:				
a. Name, Grade, SSAN				
b. Age, Sex, DOB, Race				
c. AFSC, Job Title				
d. Drug/Alcohol Incidents				
e. Means of Identification				
f. Length of Service				
g. Organization				
2. Summary of Evaluation				
a. History of Present Abuse:				
(1) Pattern of Abuse				
(2) Quantity of Substance				
(3) Environment of Substance Abuse				
(4) Frequency of Abuse				
b. Family History:				
(1) Reference Local Community				
(2) Substance Abuse in Family				
(3) Interpersonal Family Relationships				
(4) Extended Family Relationships				
c. Past History:				
(1) When Abuse Began				
(2) School History				
d. Military History				
(1) History of Assignments				
(2) Substance Abuse in the Military				

ATCH 1

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	S	NI	U	Comments
(3) Administrative Actions				
(4) Judicial Actions				
(5) Performance Data				
3. Summary of Social Actions Evaluations				
a. Rehabilitation Committee Evaluation Summary				
b. Counselor Evaluations				
c. Participate in Other Rehabilitation Programs				
4. Summary of Social Actions Program				
a. Type of Program(s)				
b. Evaluation of Rehabilitee's Participation				
5. Recommend Actions				
6. Marking				
a. Proper Marking				
b. Proper Transmittal				

	S	U
Overall Evaluation		

A minimum of 19 satisfactory grades is required for an overall grade of satisfactory.

Student Acknowledgement of Grade _____

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Rehabilitation Summary
GRADING CRITERIA FOR HO-B-IV-1-18-C (Cont'd)

	Satisfactory	Needs Improvement	Unsatisfactory
1. Identifying Data			
a. Name, Grade SSAN	Information indicated		Information omitted
b. Age, Sex, DOB, Race	Information indicated		Information omitted
c. AFSC, Job Title	Information indicated		Information omitted
d. Drug/Alcohol Incidents	Information indicated		Information omitted
e. Means of Identification	Information indicated		Information omitted
f. Length of Service	Information indicated		Information omitted
2. Summary of Evaluation			
a. History of Present Abuse:			
(1) Pattern of Abuse	Level of involvement noted, substance(s) abused, degree substance is a part of life style	Information stated but requires more clarification than is present to be properly understood	Information not included or inadequately presented
(2) Quantity of substance	Amount of the substance abused	Information not clearly stated	No indication item omitted
(3) Environment of substance abuse	Where, when and with whom indicated	Item addressed but not clearly defined	Environment not mentioned
(4) Frequency of abuse	How often substance is abused	More expansion needed	No indication
b. Family History:			
(1) Reference local community	City, State, etc. noted	Only part of the information is present	Item omitted

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(2) Substance abuse in the Family	Reference made to substance abuse in the family	Information not clear or needs expansion	Item omitted too vague or inadequate
(3) Inter-personal family relationships	Overview of relations with immediate family	Information needs clarification to be understood	Information misleading, too general or omitted
(4) Extended family relations	Overview of relations with extended family members	Information needs clarification to be understood	Information misleading, too general or omitted
c. Past History:			
(1) When abuse began	When abuser first began using the substance	Information needs clarification	Item omitted or not enough information for an assessment
(2) School History	Level of education, schools attended from high school to present	Information present but too general	Not enough information or omitted
d. Military History:			
(1) History of assignments	Overview of dates and places of military assignments	Requires expansion	Information too scanty, omitted or incomplete
(2) Substance abuse in the military	When substance abuse began in the military	Information not clearly presented	Information omitted or incomplete
(3) Administra-tive actions	Reference made to administrative actions taken	Information not clearly presented	Information incomplete or omitted
(4) Judicial actions	Reference made to judicial actions taken	Information not clearly stated	Information incomplete of or item omitted
(5) Performance data	APRs/OERs, commander or supervisor evaluations or comment	Information not clearly stated	Information incomplete or item omitted
3. Summary of Social Actions Evaluations			
a. Rehabilitation Committee Evaluation Summary	Overview of the Committee evaluations	Evaluations not clearly indicated	Information incomplete or item omitted

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Social Actions Training Branch
USAF Sch of Applied Aerosp Sci (ATC)
Lackland AFB, TX 78236

HQ 3ALR73430B/30LR73618/
30ZR7364B - 1V - (1) - [illegible]

INTAKE INTERVIEW DOCUMENTATION PROGRESS CHECKLIST

STUDENT NAME _____ RANK _____ INSTRUCTOR _____

GROUP # _____ EVALUATION _____ REMAKE _____ DATE _____

CONTENTS OF SESSION	S	NI	U	(CIRCLE)	COMMENTS
1. INTRODUCTION TO SOCIAL ACTIONS				S U	(ALL MUST BE CORRECT)
a. Explain reason for referral to Social Actions					
b. Determine clients feeling about referral					
2. ORIENTATION				S U	(ALL MUST BE CORRECT)
a. Clarify Social Actions role.					
b. Explain the Drug/Alcohol Rehabilitation Program including LPCP.					
c. Explain limitation of confidentiality					
3. DEMOGRAPHIC DATA				S U	(ALL MUST BE CORRECT)
a. Emphasize Privacy Act					
b. Name, grade, SSAN					
c. Age, sex, race, DOB					
d. AFSC, job title					
e. Length of service					
f. Length of time at present base.					
g. Bases of assignment by year					
h. Unit, duty section, current supervisor					
i. Drug/alcohol incidents					
4. SOCIAL HISTORY					
a. History of alcohol/drug abuse.				S NI U	(SUBJECTIVE)
(1) Pattern of abuse.					
(2) Clients perception how pattern effects behavior and feelings					
(3) Attitudes toward use of drug/alcohol					
b. Job performance				S NI U	(SUBJECTIVE)
(1) Job satisfaction					
(2) Relationship w/supervisor					
(3) Relationship w/co-worker					
(4) Description of work problems					
(5) History of job assignments					
(6) Intention to remain in military					
(7) Performance reports/ (ratings)					

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INTAKE INTERVIEW DOCUMENTATION PROGRESS CHECKLIST

CONTENTS OF SESSION	S	NI	U	COMMENTS
c. Judicial/Nonjudicial occurrences				S U (ALL MUST BE CORRECT)
(1) Article 15's				
(2) Letter(s) of reprimand				
(3) Courts Martial				
(4) Civilian legal problems				
d. Education				S U (ALL MUST BE CORRECT)
(1) Level				
(2) Current enrollment in school				
(3) Academic/vocational/professional				
(4) Military				
e. Family history				S NI U (SUBJECTIVE)
(1) Marital status				
(2) Relationship w/children/spouse				
(3) Homelife activities				
(4) Financial problems				
f. Social Life				S NI U (SUBJECTIVE)
(1) Recreational activities				
(2) Hobbies				
(3) Community				
(4) Problems not conforming to Air Force standards				
g. Attitude toward self				S NI U (SUBJECTIVE)
(1) Strengths/weakness				
(2) Views self				
(3) Activities interested in				
(4) Conforming to AF standards				
5. CLIENT's PREFERENCE FOR REGIMENTATION				S NI U (SUBJECTIVE)
a. Type of rehabilitation				
b. Feeling about referrals/or rehabilitations activities				
6. REFERRALS (OPTIONAL AS APPROPRIATE)				S NI U (SUBJECTIVE)

GRADING INSTRUCTIONS:

S = Satisfactory
NI = Needs Improvement
U = Unsatisfactory

OF THE MAJOR HEADINGS CIRCLED the Overall Grade is determined by the following:

S = 2 or less NIs, with No Unsatisfactories

U = 3 or More NIs, with any Unsatisfactories

OVERALL EVALUATION S U

Student Acknowledgement

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b.	Counselor Evaluations	Overview of the evaluations of the counselor(s) involved	Evaluations too general	Information incomplete or item omitted
c.	Participation in other rehabilitation programs	Participation referenced	Information not clearly presented	Incomplete or omitted
4.	Summary of Social Actions Program			
a.	Type of Program(s)	Outline of the type of program(s) individual participated in	Information not clearly stated	Information incomplete or omitted
b.	Evaluation of the rehabilitee's participation	Explanation of evaluation of participation in the specific program	Information not clearly stated	Incomplete or omitted
5.	Recommended Actions	Social Actions recommendation for program support during the TDY	Recommendations not clear or vague and general	Incomplete or omitted
6.	Marking	Proper markings used		Improper marking used

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INTAKE INTERVIEW DOCUMENTATION

GRADING CRITERIA FOR

HO-B-IV-1-19-C (Cont'd)

	SATISFACTORY	NEED IMPROVEMENT	UNSATISFACTORY
1. Introduction to Social Action			
A. Explain reason for referral to Social Actions	Stated clearly and concisely	N/A	Reasons omitted or incorrect
B. Determine clients feeling about referral	Stated clearly and concisely	N/A	Omitted or incorrect
2. Orientation			
A. Clarify Social Actions role	Stated clearly and concisely	N/A	Omitted or incorrect
B. Explain the Drug/ Alcohol Rehabilitation Program including LPCP	Stated clearly and concisely	N/A	Omitted or incorrect
C. Explain limitation of confidentiality	Stated clearly and concisely	N/A	Omitted or incorrect
3. Demographic data			
A. Emphasize privacy Act	Stated clearly and concisely	N/A	Omitted or incorrect
B. Name, Grade, SSAN	Complete information	N/A	Omitted or incorrect
C. Age, Sex, Race, DOB	Complete information	N/A	Omitted or incorrect
D. AFSC, Job Title	Complete information	N/A	Omitted/incorrect
E. Length of Service	Complete information	N/A	Omitted/incorrect
F. Length of time at present base	Complete information	N/A	Omitted/incorrect

Attachment 4

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	SATISFACTORY	NEED IMPROVEMENT	UNSATISFACTORY
G. Bases of assignment by year	Complete information	N/A	Omitted/incorrect
H. Unit, Duty Section Current Super	Complete information	N/A	omitted/incorrect
I. Drug/Alcohol incidents	Complete information	N/A	Omitted/incorrect
4. Social History			
A. Legal Abuse			
(1) Pattern of abuse	How long and how often has Drug/Alcohol been abused	Information not clearly stated.	Too little information or omitted
(2) Client's perception how pattern effects behavior and feeling	Clear statement of clients perception of his/her own behavior	statement not needs expansion	information omitte
(3) Attitudes toward use of Drug/Alcohol	Clear statement of counselee's attitude	Statement not clear-be more specific	Information omitted
B. Job Performance			
(1) Job Satisfaction	Clear statement of counselee's feeling about job	information not clear	Information omitted
(2) Relationship with supervisor	Overview of relations with supervisor	Information needs clarification	Information too general or omitted
(3) Relationship with coworker	Overview of relations with coworker	Information needs clarication	Information too general or omitted
(4) Description of work problems	A brief overview of his/her work problems	Information should be more specific	Information/ incomplete/ omitted
(5) History of job assignments	An overview of job assignment	Requires expansion	Information too scanty, omitted or incomplete
(6) Intention to remain in military	A brief statement of clients intention to remain in military	Information not clearly stated	Information incomplete or omitted

	SATISFACTORY	NEED IMPROVEMENT	UNSATISFACTORY
(7) Performance Reports (Ratings)	A brief overview of performance report rating	Information not clear	Information incomplete/ omitted
C. Judicial/non judicial occurences			
(1) Articles 15	Complete overview of occurences		Omitted/incorrect
(2) Letter(s) of reprimand	Complete overview of occurences		Omitted/incorrect
(3) Court Martials	Complete overview of occurences		Omitted/incorrect
(4) Civilian Legal problems	Complete overview		Omitted/incorrect
D. Education			
(1) Level	Highest degree		Omitted/incorrect
(2) Current enrollment in school	Reference made to course enrollment in school		
(3) Academic/ vocation at profession	Professional training outside of military		Incomplete or omitted
(4) Military	Overview of schools attended		Incomplete or ommited
E. Family History			
(1) Marital status	State correctly		Incorrect or omitted
(2) Relationship with children/spouse	Overview of relations with family members	Information not clearly stated	Incomplete or omitted
(3) Home life activities	Overview of activities with family	Information not clearly stated	Incomplete or omitted
(4) Financial problems	Clearly stated	Not clear	incomplete or omitted

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	SATISFACTORY	NEED IMPROVEMENT	UNSATISFACTORY
F. Social Life			
(1) Recreational activities	Overview of activities	Information not clear	Too general or omitted
(2) Hobbies	Overview of pastime client enjoys	Information too general/not clear	Omitted or incomplete
(3) Community	Overview of community activities client has/does engage in	Information not clear	Omitted or incomplete
(4) Problems not conforming to Air Force standards	Overview and client findings about problems with conforming to standards	Information not clear	Omitted or incomplete
G. Attitude Toward Self			
(1) Strengths/weaknesses	Clients perceptions clearly stated strengths/weakness	Information not clear	Omitted or incomplete
(2) Views	Clearly stated overview	Not clear	Incomplete or omitted
(3) Activities interested in	Overview of clients activities	Not clear	Too general
(4) Conforming to Air Force standard	Reasons stated clearly	Not clear	Incomplete or omitted
5. Clients Preference for regimen			
A. Type of rehabilitation	Outline of type of program preferred	Information not clear	Incomplete or omitted
B. Feeling about referrals or rehabilitation activities	Overview of feelings of both referrals/rehabilitation activities	Information too general	Incomplete or omitted
6. Referrals (optional)	Reasons clearly stated	Reasons not clear	Reasons omitted

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SOCIAL ACTIONS TRAINING BRANCH
LACKLAND AIR FORCE BASE, TEXAS

HO 3ALR73430B/3OLR7361B/
3OZR7361B-IV-1-23-1
27 August 1976

Roles for Intake Interview Session

1. Instruction.

a. These roles will be used during the Social Actions Program Management Group time specified as Administrative Practicum.

b. Do not allow students to use this Handout other than in a Role-Play situation.

c. Inform students that this exercise is for evaluation and not practice.

d. Divide the group into dyads and choose one of the roles as outlined below. Simulate one role as a client while the other student acts as the counselor.

e. At the end of 25 minutes reverse the positions and use the second role for the next 25 minutes.

f. During the role-play situation, each "counselor" should take adequate notes, in order to write an Intake Interview.

g. After each role has been completed, document the Intake Interview Session using the Case File Documentation Evaluation Checklist.

2. Role Playing Situations.

a. DRUG ABUSER. Here the counselee was identified as a user of marijuana and LSD who was arrested by Security Police during a random search on private vehicles for possession of 1/4 ounce of marijuana. The counselee does not see drugs as a problem since they haven't been medically determined as harmful substances, however, the "system" which harasses users is the real problem. For these reasons, the counselee does not see that rehabilitation is really necessary but will go along with the program. This incident was discussed with the unit commander who is initiating Article 15 action. There is some concern that the apparent religious, mind expanding experience which the counselee enjoys will stop if the use of the drugs is discontinued. Areas for elaboration in this role include: willingness to participate in the rehabilitation program; any related problems, financial, on-the-job, medical, legal, etc; the pattern of use, such as environment, how often, how long the drugs have been used. The unit commander has identified the individual for entry into the program. The counselee elaborates on these areas only if requested by the counselor.

b. ALCOHOL ABUSER. Here the counselee has been identified as a habitual excessive drinker who was arrested for driving while intoxicated (DWI) by local civilian police and reported to the unit commander by the AF Security Police. The counselee does not see that there is an alcohol problem other than occasionally drinking too much. Since this is the first incident of DWI, or other alcohol-related incidents, the abuser does not see the necessity of rehabilitation. This incident has been discussed with the commander who

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indicated that some action will be taken but that action has not been determined. There are marital problems at home concerning debts and as a result there is a possible divorce pending. Suggested areas for elaboration in this role include: acceptance or rejection of the rehabilitation program; financial, medical, marital areas; the drinking pattern; how often alcohol is abused; the drinking environment, such as place, friends, alone, type of alcohol. The commander has formally identified the counselee as an alcohol abuser. The counselee elaborates on these areas only if requested by the counselor.

ATCH 5

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PLAN OF INSTRUCTION/LESSON PLAN PART I

NAME OF INSTRUCTOR	COURSE TITLE
	Drug and Alcohol Abuse Control
BLOCK NUMBER: IV	BLOCK TITLE: Program Management and Application

COURSE CONTENT

2. Supervisor Confrontation Model

a. Identify techniques supervisors should use to confront personnel suspected of alcohol abuse.

SUPPORT MATERIALS AND GUIDANCE

Student Instructional Materials
HO B-IV-2-9, Supervisor Confrontation Model

Audio-Visual Aids
35mm Slides, Supervisor Confrontation Model
16mm Film, Need for Decision (FLC14-88, 10 min)
16mm Film, Weber's Choice

Training Methods
Lecture
Discussion

Instructional Guidance
Outline the "Constructive Confrontation Model," as presented by H. Trice in Spirits and Demons at Work: Alcohol and Other Drugs on the Job. Stress the supervisor role in the problem drinker (alcoholic) identification process. Emphasize the need for early recognition and adequate documentation of job performance. Discuss referral from the job for problem confirmation and program entry. Caution students about the need to involve medical personnel. Provide role-playing confrontation exercises to reinforce lesson objectives.

SUPERVISOR APPROVAL OF LESSON PLAN (PART II)

SIGNATURE AND DATE	SIGNATURE AND DATE

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HANDOUT

3ALR73430B/30LR7361B/30ZR7364B-IV-5-9

Technical Training

Drug and Alcohol Abuse Control

SUPERVISOR CONFRONTATION MODEL

July 1977

Headquarters 3250 Technical Training Wing (ATC)
(USAF Technical Training School)
Lackland Air Force Base, Texas 78236

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ATC FORM 214 (JAN 78) OBSOLETES ATC FORMS 214, MAY 69, 522, NOV 63 AND 523, MAY 71. STANDARD COVERSHEET

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Social Actions Training Branch
Lackland Air Force Base, Texas

HO 3ALR73430B/3OLR7361B/
3OZR7364B-IV-5-9
12 July 1977

ALCOHOL CONFRONTATION MODELS

ALCOHOLISM

A SUPERVISOR GUIDE

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HO 3ALR73430B/30LR7361B/30ZR7364B-IV-5-9

FORWARD

Air Force is concerned about the well being of its personnel. Our men and women with drinking problems, as well as other burdens of a sensitive, personal nature, need and are worthy of our special attention and total commitment.

Problem drinkers can be restored. The potential, long range economic and humane gains can hardly be estimated. With this knowledge, a program for identification and rehabilitation has been developed, in which you - the commander and supervisor, occupy the key position of recognition and referral of the problem employee. Without your full support our efforts will be wasted. You are therefore challenged to execute your responsibilities with dedication and persistence.

Like any new program, constant review and change will be required, as different procedures are tested and proven successful, and new techniques are developed. As a natural course the recognition and referral process will expose a wide variety of emotionally based personal behavior problems, which impair the individual's occupational functioning. But a source of pride will develop from successful referral to various treatment services, and the ultimate rehabilitation of the individual, which will be gratifying to the employee, the supervisor, the commander and the Air Force.

AIR FORCE POLICY ON ALCOHOLISM

AFR 30-2

It is each person's right and responsibility to exercise his/her own judgement in the use of alcohol when not otherwise restricted by public law or military directives. A member's private drinking habits that do not affect public behavior or duty performance are not in question and will not be investigated.

When, however, a determination is made that altered work performance and behavior are not a transitory phenomenon, and represent deviations from accepted military standards, which are adversely affecting mission accomplishment, the situation becomes a matter of deep concern to immediate supervisor, unit command, and the Air Force.

In an effort to deal realistically and uniformly with the problem of alcoholism, the Air Force has adopted the following policy.

_____"Alcoholism is preventable and treatable".

_____Alcohol Abuse Control Program goals are to:

a. "Prevent alcohol abuse and alcoholism among Air Force members".

b. "Restore to effective functioning persons with problems attributable to the abuse of alcohol".

c. "Insure humane management and disposition of those who cannot be restored or who do not remain restored".

_____"Policies on standards of behavior, performance and discipline are affirmed and will be firmly maintained." These standards, will be

applied, however, to each person's demonstrated conduct rather than to his use of alcohol".

"Commanders must respond to unacceptable behavior or performance with prompt and appropriate corrective actions".

THE TASK

Alcoholism is one of our nation's four most serious health problems, affecting one out of every twenty people in the occupational environment. Each year the economy is drained of over $25 billion and immeasurable human suffering is perpetuated. Alcoholics Anonymous, industry and the professional and paraprofessional helping agencies have demonstrated that the progression of this condition can be halted, and, in fact, reversed, and the individual restored to physical, psychological, and social well being and productivity.

The task is to bring our supervisory skills, as managers of people, and concentrated efforts through positive actions, to bear on the problem. Only then can we say that we are worthy of the title, LEADERS.

WHAT IS ALCOHOLISM?

Alcoholism is a psychological/physical dependency on alcohol that leads to a person's misconduct, or unacceptable social behavior, or to the impairment of his/her duty performance, physical or mental health, financial responsibilities or personal relationships.

The quantity of alcohol consumed is not necessarily the indicator of alcoholism, nor is the frequency of use. Initially the alcoholic cannot consisitently choose how much or how long he will drink; and as his involvement deepens, he looses the ability to consistently choose when he will drink. If unchecked, this growing preoccupation with alcohol leads to a total loss of control over its consumption and the ultimate destruction of the individual.

Alcohlism is a highly complex condition, to which anyone, regardless of race, religion, ethnic background, social class or occupation position is vulnerable. It would seem to have no single cause, but rather to be an end product, resulting from the action of many physiological, psychological and sociological pressures upon an individual.

Alcoholism is progressive and destructive. But it <u>can</u> be successfully treated, if detected. The suffere <u>can</u> be restored. His/her chances for a successful recovery are a direct function of the timeliness of problem recognition and referral. Once identified and enrolled in a comprehensive rehabilitation program, the prognosis is excellent.

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YOUR RESPONSIBILITY AS COMMANDERS & SUPERVISORS

it is your responsibility to :

a. Insure mission accomplishment.

b. Maintain the highest possible standards of performance and behavior within your organization.

c. Insure quality, efficiency, harmony and safety on the job.

d. Confront unacceptable job performance or behavior.

e. Advise and counsel problem workers.

f. Correct deficiencies which affect mission accomplishment, compromise standards or safety, and/or disrupt the smooth flow of job activity.

Our policy with respect to alcohol abuse and alcoholism is entirely consonant with this responsibility and represents a long needed, affirmative step in our efforts to show genuine, personal concern for the welfare of our members.

As their leaders, you are <u>not</u> tasked to be diagnosticians; but <u>are</u> charged to confront unacceptable performance or behavior, whatever the cause, and on that basis, to take immediate and appropriate corrective actions.

Refusing to admit the existence of the problem; ignoring it because of friendship, long term service and stigma; or considering immediate dis-

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ciplinary action, transfer or separation, serve only to demonstrate our inability and unwillingness to confront the problem and carry out our assigned responsibilities. Once entrapped by alcoholism the problem drinker is unable to help himself/herself, and in most cases, if left to his/her own devices, will ultimately cause his/her own destruction. Timely intervention by supervision is the key to a positive control program and can mean the difference between success or failure in each individual case encountered. Even after ignoring the pleas of the family, or friends, the problem drinker will frequently be shocked into accepting assistance, when he/she is confronted with the probability of losing his/her job and career. Our intent is not that this threat becomes a reality, but that it will serve, as a last resort, to motivate the individual to treatment and restoration.

AFR 30-2
CHAPTER 5 SUPERVISOR MUST:

_____"Become acquainted with the alcoholism program and lend support to it".

_____"Become familiar with corrective procedures to rehabilitate personnel and disciplinary policies as they relate to the alcoholism program".

_____"Recognize problem drinkers through substandard performance and behavioral problems".

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_____"Respond to unacceptable behavior or performance with prompt and appropriate corrective actions".

_____"Assist problem drinkers in problem recognition and seeking treatment and rehabilitation".

RECOGNITION

The prolonged departure from pre-established patterns of performance or behavior suggests a problem. No single, observable sign is significant, but should fit into an overall pattern, which indicates a change in the individual. The recognition process is not a "witch hunt". The suspicion that the member is different, his/her performance or behavior is out of character, or that something is wrong should precede investigation. Once the suspicion of an ongoing problem is confirmed, the following recognition process is recommended, in order to initiate resolution. This four stage model, although expanded here for alcoholism, is applicable to any problem situation of a non-production nature, and only requires changes in the specific behaviors listed. The characteristics of the individual stages, as viewed by the Supervisor, remain unchanged; and the actions required are identical.

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THE FOUR STAGE RECOGNITION PROCESS

STAGE 1 - DISRUPTIVE - BUT - NORMAL (several years) - ACTION - INTERVIEW[1]

I. Stage Characteristics

a. Intermittent disruption of performance or behavior

b. Undefined deviation from the expected

c. Not frequent or disruptive enough to indicate abnormality

d. Few dynamic symptoms

II. Behaviors - UNDEFINED - BUT - DIFFERENT

a. Increased nervousness

b. Hangovers

c. Avoidance of supervisors

d. Morning drinking

Reported by Drinkers not necessarily observed

e. Unexcused/temporary absences

f. Unusual excuses for half or whole day absences

g. Decline in work quality and quantity

h. Mood changes after temporary absences, breaks or lunch

i. Frequent tardiness

Observed by Supervisors

[1]Harrison Trice, Spirits and Demons at Work: Alcohol and Other Drugs On the Job (New York: Cornell University, 1972).

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III. Conclusions

a. Abuser is integrating drinking into his normal work role.

b. His/her behavior may be recognized by his/her fellow workers

c. Little concrete evidence to permit confrontation. However, an interview, discussing the presence of any problems, is definitely appropriate. If the problem were surfaced, prognosis would be excellent.

STAGE 2 - BLOCKED AWARENESS - ACTION = COUNSELING/CONFRONTATION

I. Stage Characteristics

a. Awareness of departure from pre-established patterns of performance and behavior is increasing.

b. Behavior can often be linked directly or indirectly to drinking.

c. Barriers exist to problem definition

(1) Drinking takes place away from the central work place.

(2) Fellow workers hesitate to define behavior as "abnormal", even though it is connected to drinking.

(3) The higher the individual's job status the less likely that his behavior will be connected to drinking. He/she is less vulnerable and often more able to structure his/her own time with respect to being at the central work location.

(4) Friendships, experience and past performance make identification uncomfortable.

II. Behaviors - Needs Increased Supervision

a. Increased absenteeism

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b. Further decline in work quality and quantity (may neglect detail, errors in procedure)

c. Hangovers

d. Inattentiveness on the job

e. Breath purifiers

f. Watery eyes

g. Unexplained temporary absences from the central work place

h. Change in dress habits (can become very neat or begin getting careless)

i. Missed suspense dates

j. Forgetful and indecisive

k. Tendency to blame others for failing and make excuses

l. Excessive discussion time reduces available work time

III. Conclusions

a. Still may not be enough direct evidence to connect the individual with drinking

b. Fellow workers can connect behavior to drinking, but hesitate to define the problem

c. Existing friendships and stigma block identification

d. Counseling/confrontation is indicated. The prognosis would still be good to excellent.

STAGE 3 - SEE-SAW - ACTION = CONFRONTATION

I. Stage Characteristics

a. Increased job impairment

b. Steady accumulation of aggravative behavior

c. Still tolerated by fellow workers

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II. Behaviors - CANNOT DIAGNOSE BUT CAN CONFRONT

a. Bleary or reddish eyes

b. Frequent complaints of colds or flu to explain physical appearance

c. Hand tremors

d. Excessive attendance at "sick call"

e. Unreceptive to change or suggestions

f. Sharp personality changes (linked with temporary absences from the job location)

g. Frequent loud talking

h. Unreasonable excuses for behavior or absences

i. Frequent blaming of others for failing

j. Spasmodic work pace (unpredictable and often exceptional, see-saw)

k. Argumentative and defensive

l. Periods of normalcy (see-saw)

m. Intentional, visible drinking pattern, which precludes suspicion (see-saw)

n. Increased supervision required

o. Difficult to locate when wanted (absent)

p. Periods of uncommon over-confidence

q. Repeats procedures unnecessarily, delaying completion of tasks

III. Conclusions

a. Supervisor questions his/her qualifications to label the problem. He/she is not sure.

b. Supervisor does not have to be able to define or diagnose

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the condition, in order to take action.

c. Counseling and confrontation are mandatory on the basis of the unacceptable performance or behavior. Recovery prognosis is good.

STAGE 4 - DECISION TO RECOGNIZE - ACTION = CONFRONTATION

I. Stage Characteristics

a. Accumulated observations tip the scales

b. Unable to communicate with the individual

c. Cannot rationalize or justify ignorance of the problem

d. Fellow workers redefine the behavior as abnormal, and withdraw

II. Behaviors - CANNOT COMMUNICATE OR REASON WITH INDIVIDUAL

a. Excessive absenteeism (half and full day)

b. Totally avoids supervisor

c. Hardly ever available for discussion

d. Flushed or swollen face

e. Tremors and sweats

f. Withdrawn (loner)

g. Liquor on breath

h. Change in weight (poor diet)

i. Excuses for absence, or failure to comply, are unreasonable sometimes bizarre, and repetitive.

j. Productivity very low

k. Fellow workers complain

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l. Moody, defensive, and irritable

m. Communication is at a standstill

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III. Conclusion

a. Supervisor is forced to identify and diagnose the problem, to avoid being cited by higher authority.

b. Chances for successful recovery by the individual are minimal.

SUMMARY: It should be noted that all of the observable behaviors listed do not necessarily fit any one individual, nor do they appear in a particular order over a specific time period. Each case is unique, and is defined by its own body of indicators, which separate the member from his/her pre-established patterns of behavior and performance and precipitate problem identification.

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PROBLEM DOCUMENTATION

As a supervisor you should know your personnel and maintain written records of meetings with them and actions taken which pertain to them. These documents should be reviewed periodically, as a part of your basic responsibility to insure the effective mana, ment of your personnel and resources, and in order to uncover any trends, positive or negative, which may be emerging.

With respect to alcohol abuse and alcoholism, the documented record of performance discrepancies noted, unacceptable behaviors observed, interviews, or counseling sessions held, and actions taken will become the basic element of confrontation with the problem member. It will also serve as an informational summary for higher supervision, problem consultants (Social Actions, medical and chaplain), and the Unit Commander, and as a case history supplement for referral agencies, during the treatment and rehabilitation effort. Since you are <u>not</u> being asked to diagnose the cause of the problem, and further, will <u>not</u> be confronting the member on that basis, no accusation nor supposition that drinking is the issue should be included.

The following list of items for documentation has been compiled. It in no way constitutes a complete record, and should be expanded as necessary to fit each specific situation.

Maintain written record of the following:

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a. Absences and excuses

b. Failure to comply

c. Failure to follow orders

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d. Missed suspense dates

e. Appearance discrepancies

f. Reports to sick call

g. Tardiness

h. Unsatisfactory performance

i. Unacceptable behaviors

j. Disciplinary actions

k. Interviews

l. Counseling sessions

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CONFRONTATION

Confrontation between the supervisor and the problem member should take place at the earliest possible time; but only after it has been determined that the deviations documented do not represent a transitory phenomenon, but do identify a significant departure from pre-established personal patterns and/or acceptable standards.

The following confrontation sequence is suggested as a guide:

Step 1 - Supervisor Action

a. Supervisor may know the cause of the performance or behavior change and can take appropriate action to help the employee correct it.

b. The problem may be of a nature that the supervisor wishes to discuss things with his/her supervisor prior to seeing the worker.

c. The supervisor may wish to discuss the problem and his/her observations with his/her supervisor and a specialist (Social Actions, Medical, Chaplain).

NOTE: When in doubt about option "a", execute option "b". If still not sure, also take "c".

Step 2 - First Meeting

a. Confront employee on a friendly, questioning basis as to the decline in job performance and/or prevalence of unacceptable behavior.

b. Show the employee the written documentation of the observations.

c. Express your concern for a possible problem that he/she might have, and your willingness to assist.

d. Request his/her explanation of the unacceptable performance.

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c. Advise the employee that the situation must be corrected or action will be taken.

f. Schedule another counseling session at a later period (a week), when the situation will again be reviewed for improvement or further action.

NOTE: If the situation warrants, a referral to Social Actions, the hospital, or the chaplain may be in order. This appointment may be suggested or ordered.

NOTE: Remember that withdrawal from alcohol constitutes a medical emergency in cases of heavy dependence; and you are not qualified to make a diagnosis. When in doubt, send him.

Step 3 - Between Meetings

a. Monitor and record progress of employee during period between interviews.

b. Advise immediate supervisor of same status.

c. If no improvement is noted or the situation deteriorates, consult with specialists and plan proper approach for the second interview.

Step 4 - Second Meeting

a. If situation has improved and seems to be returning to normal, reaffirm faith in employee and remind him that you are always there to help, whenever needed.

b. If situation has deteriorated or remained status quo, the employee should be again confronted with his performance and told that no satisfactory improvement was noted.

c. He/she should be given another chance to explain his/her problem and lack of progress.

d. If alcoholism is suspected, a mandatory appointment should be made with the Social Actions Office. This appointment should be made without delay. Other problems might indicate referral to the Legal Office, the Chaplain, Personnel Office, or Medical Facility.

e. The supervisor should insure that the employee keeps the appointment, and provide the referral agency with background case data as applicable.

f. The supervisor should advise the employee of the grave consequences of continued poor performance - Article 15, Separation, etc.

NOTE: Anytime the employee admits his/her drinking problem, an appointment should be made with the SAO and assurance given as to the positive policy of the Air Force and the Unit.

NOTE: Rehabilitation must be offered to every individual, even when dismissal is contemplated. Enrollment in treatment program is mandatory whether the individual is a volunteer or not.

NOTE: Industry has found that only 50% of the cases referred using these guidelines are diagnosed as alcoholism. Others include emotional disturbance, family problems, job dissatisfaction, and some physical ailments.

NOTE: Do not attempt to diagnose the problem, unless physical evidence is present, legal difficulties arise, or help is voluntarily solicited.

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REFERRAL

After the Identification, Documentation, and Confrontation processes have taken place, referral of the member should be made if problem resolution cannot be routinely accomplished by the unit through general supportive guidance or counseling. As a supervisor, your skills, primary experience, and time are focused on task completion, and mission accomplishment. The referral of a problem worker to a helping agency should not be viewed as a sign of inability or weakness, but as a positive decision based on mature judgement.

Some principles for timely referral are included as a guide:

- Anytime personal problems are indicated which cannot be resolved by the unit, referral should be made to the appropriate agency by way of suggestion or assignment (SAO, Chaplain, Legal, Medical).

- Counsel by personnel with special qualifications in a suspected problem area is often successful, because of the special experience of the people involved and their location.

a. The privilege of confidentiality can often provide the necessary stimulus for uncovering the trouble.

b. People often loosen up when away from the problem environment.

- Referral for problem drinking or suspected alcoholism should be made to the Social Actions Office or directly to the hospital, if necessary.

- All referrals should be preceded by consultation between the

unit and the involved agency(s).

NOTE: Irregardless of the referral route used, a complete medical evaluation should begin the rehabilitative process.

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BEYOND REFERRAL

In dealing with problems such as alcoholism which will require specialized treatment techniques and approaches, the most appropriate program, designed to meet the specific needs of the individual concerned, will be selected and coordinated between the Unit Commander, the Chaplain, Medical professionals, and the Social Actions Office. Persons who require intensive care and rehabilitation beyond local capability will be entered into an Air Force Centralized Rehabilitation Facility. Dependents of military personnel and DAF civilian employees, if authorized medical care, may also receive assistance for problems of alcohol abuse or alcoholism. Otherwise, they should be encouraged to seek civilian assistance. CHAMPUS approved facilities should be considered.

STUDY REFERENCE-SUPERVISORS CONFRONTATION MODEL

5 a. CRITERION OBJECTIVE: Identify the indications of an individual's progressing decline due to alcohol abuse, that are observable by a supervisor, and the barriers that a supervisor faces in openly defining the problem.

1. Role of the supervisor in relation to alcoholics/alcohol abusers.

a. Recognize problem drinkers through substandard performance and behavioral problems, corrective actions. Use the following steps:

(1) Recognize (Identify).

(2) Document.

(3) Confront.

(4) Refer.

2. Symptoms that are observable:

a. Few dynamic symptoms.

b. Intermittent disruption of established performance or behavioral patterns.

c. Undefined deviation from the established patterns of behavior.

d. Not frequent or disruptive enough to indicate abnormal behavior.

e. Deviations increase.

3. Barriers to confrontation:

a. Drinking away from work area.

b. Covered for by fellow-workers.

c. Higher the individual the more time structure for drinking.

d. Closeness to individual makes confrontation uncomfortable.

4. Soon the problem becomes obvious.

a. Job impairment increases.

b. Aggravative behavior.

c. Still covered by fellow-workers.

d. Communication lost.

e. Must face problem.

f. Fellow-workers withdraw.

5. Look for formation of a problem drinking pattern.

a. Hangovers.

b. Morning drinking.

c. Avoidance of supervision.

d. Spasmodic work pace.

e. Unexcused absenteeism.

f. Tardiness.

g. Decline in work quality.

h. Inconsistant dress habits.

i. Sharp personality changes.

j. Unreasonable excuses for behavior or absences.

k. Paranoia.

l. Argumentative and defensive behavior.

m. Change in weight.

n. Fellow-workers complaints

o. Withdrawal from social interaction.

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p. Flushed, swollen face.

q. Tremors or sweats.

r. Showing up on security police or local police blotters.

5b. Identify four major areas which should be documented by supervisors when alcohol abuse is suspected.

1. Document:

a. Word performance

b. Behavior

c. Number of counseling sessions held

d. Action taken against individual.

2. Specifics: Absences
Failure to comply
Failure to follow orders
Appearance discrepancies
Excessive reports to sick call
Unsatisfactory work performance
Tardiness
Missed suspense dates

5c. Identify two basic requirements for confronting and the recommended supervisor actions during the first and second meetings with the worker.

1. First Confrontation:

Confront at the earliest possible time
Confront on a friendly, questioning basis
Show documentation
Offer assistance
Request an explanation
DO NOT MENTION ALCOHOLISM
Schedule another counseling session

2. Between Meetings:

a. Monitor and record any progress

b. Advise immediate supervisor 922

c. If deterioration or, no improvement consult

Social Actions Medical Doctor
Chaplain Commander

3. Second Confrontation:

a. If situation is improved, praise the worker.

b. If situation has not improved, more drastic action is required up to and including Article 15 and possibly separation.

5 d. Identify three reasons for supervisor referral of a suspected problem drinker and the primary reason for involving competent medical authority as soon as possible.

1. Reasons for Referral:

a. Qualified counselors may be more successful.

b. Confidentiality can provide stimulus for uncovering problems.

c. People often loosen up when away from the problem environment.

2. Involve competent medical authority as soon as possible because:

a. The alcoholic may be suffering from withdrawal symptoms.

b. ALCOHOL WITHDRAWAL CAN CONSTITUTE A MEDICAL EMERGENCY.

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PLAN OF INSTRUCTION/LESSON PLAN PART I

NAME OF INSTRUCTOR	COURSE TITLE
	Drug and Alcohol Abuse Control

BLOCK NUMBER	BLOCK TITLE
IV	Program Management and Application

1 **COURSE CONTENT**

3. Alcohol Rehabilitation Models

a. Identify AF Policies and Programs established by the Air Force for conduct of centralized Drug/Alcohol Rehabilitation.

b. Identify and promote programs which offer alternative activities to alcohol abuse.

c. Identify methods of formulating rehabilitation regimens using Alcoholics Anonymous as a resource.

SUPPORT MATERIALS AND GUIDANCE

Student Instructional Material
SG B-IV-3-12, Alcohol Rehabilitation Models

Audio-Visual Aids
35mm Slides, Alcohol Rehabilitation Models
16mm Films, Alcoholism - The Bottom Line (AFIF 292, 30 min)

Training Methods
Lecture/Discussion

Instructional Guidance
Restate entry requirements for the centralized alcohol rehabilitation program and stress that the local program is the preferred method. Discuss the centralized approach to rehabilitation and the program elements. A representative of the centralized program can be contacted to provide this portion of the lecture; however, lesson plan back-up is required. Explain aversion therapy (counter-conditioning), the use of antabuse, and other modalities. Stress the danger of the careless use of antabuse. Discuss Alcoholics Anonymous and Alanon. Speakers can be secured from the local community to supplement this portion of the presentation. Allow time for student questions.

SUPERVISOR APPROVAL OF LESSON PLAN (PART II)

SIGNATURE AND DATE	SIGNATURE AND DATE

PART II - TEACHING GUIDE

INTRODUCTION (10 Minutes)

ATTENTION

The American Medical Association calls alcoholism a disease. But, this disease, alcoholism, is being treated by police personnel, judges, and jailers. This is wrong. The trend is finally changing, as public attitudes change concerning treatment and rehabilitation of the alcoholic person. I emphasize person because he/she has not become something, but is still somebody, with a heart and soul and potential for being a whole person. The trend to rehabilitation is now with doctors, therapists, and medical technicians. In many instances, the alcoholic person had been caught in the revolving door of the "establishment," the system; i.e., caught at speeding and drunk driving, or arrested for public drunkenness, dumped in the drunk tank to sleep in his/her own vomit, released after one or two days, back on the street, drunk again; the same cycle, over and over. No efforts to rehabilitate.

MOTIVATION

You are the agent, the catalyst for changing this shoddy system. In your position as Social Actions personnel, and possessing a positive attitude toward the alcoholic person, rehabilitation of half of that nine million

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alcoholics or alcohol abusers is possible. And, along with that, the savings of seven to eight billion dollars. Also, you can pull in your direction and change the attitudes of those base personnel who think rehabilitation efforts are a waste of their time and money. You have a lot going for you and, now, with the Federal Government investing some millions of dollars in alcoholism studies, you have a lot of power behind you.

OVERVIEW

1. Cover the lesson objectives with the class.

2. Explain that this hour will be devoted to those rehabilitation models for the alcoholic person that are available for you, in addition to your local rehabilitation programs. You will also see how to incorporate resources such as AA in your program.

3. Explain that in the following two hours of CTT, representatives from Alcoholics Anonymous (AA) and the Alcohol Treatment Center will speak to the class.

TRANSITION

Here are some basic thoughts about rehabilitation.

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a. These efforts might not work; but they are worth a try.

b. Much effort is needed on the part of you, the alcoholic person, the family of the alcoholic person, the supervisor, and friends.

c. Requires proper positive attitudes from family, friends, supervisors, etc.

d. Requires recognizing the problem as an illness.

e. Requires recognition of the basic symptoms of alcoholism.

f. Requires proper confrontation.

g. Requires responsibility acceptance of the individuals involved.

h. Requires a knowledge of resources available, in the community or on base.

i. Requires the ability not to get discouraged.

BODY (1 Hour 40 Minutes)

PRESENTATION

6a. CRITERION OBJECTIVE: Identify three requirements for entry into the Air Force centralized alcohol rehabilitation program.

1. State the following general information.

a. Local rehabilitation is a coordinated effort among commanders, chaplains, medical personnel, and Social Actions personnel.

b. Centralized rehabilitation is governed by Air Force Regulation (AFR) 160-36, Rehabilitation of Persons with Drinking Problems,

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which lists unit locations, entry requirements, and guidelines for operation. The office of primary responsibility (OPR) is the Surgeon General.

c. The Air Force has in operation 28-day rehabilitation centers at:

(1) Wright-Patterson AFB, Ohio.

(2) Lackland AFB, Texas.

(3) Travis AFB, California.

(4) Scott AFB, Illinois.

(5) Eglin AFB, Florida.

(6) Weisbaden AB, Germany.

(7) Lackenheath AB, England.

(8) Clark AB, Philippines.

(9) Andrews AFB, Maryland.

d. The Air Force also operates a 14-day rehabilitation center at Sheppard AFB, Texas, and Clark AB, Philippines.

2. State the entry requirements for centralized alcohol rehabilitation. Alcohol Rehabilitation Program Members recommended for Alcohol Treatment Centers must be:

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a. Referred by the rehabilitation committee. Referral to an Alcohol Treatment Center is an action which clearly must reflect the consideration of all factors in the individual case.

(1) Treatment at a central rehabilitation center is normally used only when local medical and nonmedical resources are limited.

(2) Other individual factors may impart the decision to send a person to an Alcohol Treatment Center.

(3) Each referral request to a center must be accompanied by a detailed summary outlining the efforts undertaken at the local level and the results thereof, together with all other pertinent data. This will assist the center in its evaluation and treatment of each case.

(4) The attending medical officer contacts the director of the appropriate Alcohol Treatment Center by mail or by telephone requesting admission of the patient.

(5) The originating hospital then contacts the responsible medical regulating office and obtains a cite number before entering the patient into the aeromedical evacuation system.

b. The client will undergo detoxification and withdrawal at the referring hospital before transfer if that location offers detoxification. Multiple admissions to centralized alcohol treatment programs are discouraged. Acceptance of any person having previously completed an inpatient program rests with an Alcohol Treatment Center program director. Completion of two inpatient alcohol treatment programs constitutes basis for denying a third admission. Before a third admission, serious consideration should be

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given to administrative separation and referral to a Vetrans Administration (VA) hospital for follow-up treatment.

NOTE: Not all local hospitals have the capability of detoxification. In this case detoxification is done at the nearest hospital having that capability.

APPLICATION/EVALUATION

1. What are the entrance criteria for USAF Alcohol Treatment Centers?

2. On what would you base the decision?

PRESENTATION

6b. CRITERION OBJECTIVE: Identify the approach of the centralized alcohol rehabilitation program and its six primary elements.

1. Identify the program approach. The approach is group living in separate hospital ward to promote feelings of acceptance, belonging, security, equality, and self-image.

2. Identify the six primary program elements of the 28-day centralized alcohol treatment program (excluding Sheppard AFB, Texas).

a. Individual counseling, as needed.

b. Education: Awareness about alcohol and its abuse.

c. Group therapy: Open-ended (allowing new patients in and graduates out).

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d. AA meetings: For their insight into the problem, and where patients fit in the world-wide problem.

e. Recreational therapy: Relaxation, physical conditioning, and psychological diversion.

f. Occupational therapy: Develops talents, skills, achievements, usefulness, pride, etc.

3. State the following additional information about the centralized alcohol treatment centers.

a. Alcohol treatment center program directors are encouraged to host major command (MAJCOM) and installation Social Actions personnel and unit commanders assigned within their medical (geographic) areas of responsibility. This will serve either as an orientation for unit commanders and newly assigned Social Actions personnel or a refresher for experienced Social Actions staff.

b. If considered beneficial to the rehabilitation of a patient of an alcohol treatment center, the program director may authorize the participation of the spouse in the treatment process.

APPLICATION/EVALUATION

1. What is the approach of the USAF Centralized Alcohol Treatment Centers?

2. What are the six primary program elements of the centralized treatment centers?

PRESENTATION

6c. CRITERION OBJECTIVE: Identify the roles of aversion therapy,

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antabuse treatment, therapeutic communities, and private rehabilitation centers in alcohol rehabilitation.

1. (Aversion Therapy). Discuss this as the method used at Sheppard AFB and at Clark AB.

a. Views alcoholism as a learned behavior. It is, therefore, treated as a learned behavior.

b. The alcoholic is given all the alcohol he/she wants, and even more than he/she wants, until he/she gets sick and vomits.

c. A mild electric shock is administered when drink gets to mouth.

d. Overall objective is to get the person to develop an aversion to drinking through association (unlearn the behavior through negative reinforcement or counter-conditioning).

2. Describe antabuse (disulfiram) treatment.

a. Use of a drug, administered orally, which causes the alcoholic to get ill once alcohol is mixed with drug. Reaction could consist of flushing, palpitations, hyperventilation, nausea, vomiting, and, occasionally, unconsciousness.

b. Sometimes labeled as a "crutch." (But, if someone is crippled and wants to walk, what's wrong with a crutch?)

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c. Administered by medical staff. Could be dangerous; might cause violent illness. Should never be given to an intoxicated person. Must have twelve alcohol-free hours before administering.

d. Effects last 24-96 hours.

3. Discuss the therapeutic community (alcohol recovery house).

a. Not one person doing something to patient, but a group of patients assisted by specialists.

b. Patient is encouraged to be responsible for own recovery.

4. Discuss private rehabilitation centers.

a. Concentrate on person accepting his/her responsibility for the problem, with professional assistance.

b. Recreation available; counseling; family therapy.

c. Cost for 14 days is approximately $2,100 (geared primarily to upper-economic classes).

d. Covered by some insurance companies.

e. La Hacienda, in Kerrville, Texas, with country-club atmosphere, is example.

f. Some use aversion therapy, others use a multi-modality approach.

APPLICATION/EVALUATION

1. How does aversion therapy work?

2. How does antabuse work? Can it

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be dangerous?

3. What is the greatest limitation on private rehabilitation centers?

6d. CRITERION OBJECTIVE: Identify the basic positions of Alcoholics Anonymous (AA) with respect to alcoholism, its ultimate goal, and its primary method for recovery.

1. Present general information about AA.

a. Founded in 1935 by professional people who were alcoholics.

b. Estimated 600,000 people involved today.

c. AA recognized lack of treatment available which would help alcoholics in 1935.

d. Most successful means of rehabilitation today.

2. Discuss the structure and membership of AA.

a. Membership records are not kept. Structure of an organization is virtually nonexistent. Each chapter is autonomous. Contributions maintain the chapter, pay rent, buy refreshments, etc.

b. The only requirement for membership in AA is a desire to stop drinking.

3. Discuss the position of AA with respect to alcoholism and identify its basic approach.

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a. Alcoholism can be arrested, is treatable, and alcoholics can be restored.

b. AA is a fellowship of men and women sharing experiences, strengths, and hopes, with the goal of solving their common problem and helping others recover from alcoholism.

4. Identify the ultimate goal of AA. Alcoholism cannot be cured in the ordinary sense of the term; but, it can be arrested through total abstinence from alcohol. The fellowship's sole concern is to maintain sobriety and to help others achieve it.

5. Describe the methods of program entry and recovery.

a. A member (recovering alcoholic) shares his/her story with a newcomer, describes his/her sobriety, and invites the newcomer to join.

b. Newcomer identifies with story, shares his/her problem, and unburdens him/herself for perhaps the first time.

c. Newcomer feels acceptance and begins to respond to concern.

d. The Twelve Steps of AA: the primary method for recovery.

e. Meetings.

(1) Open: For family, friends of the alcoholic, and anyone having problem with drinking.

(2) Closed: Limited to AA members.

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APPLICATION/EVALUATION

1. What is the basic position of AA concerning Alcoholism as a disease?

2. What is the goal of AA?

PRESENTATION

6e. CRITERION OBJECTIVE: Identify the 12 steps of AA.

1. Identify the 12 steps of AA as explained in the big book of alcoholics anonymous.

a. Step One. ". . . We admitted we were powerless over alcohol -- that our lives had become unmanageable. . ."

(1) For a person to admit that he/she is powerless is a difficult decision, but it is an essential component of recovery.

(2) The unmanageability comes in various forms -- financial, moral, and spiritual.

(3) The first step is considered the most important, because it is the point where the alcoholic makes a decision to stop drinking and work a program of recovery.

b. Step Two. ". . . came to believe that a Power greater than ourselves could restore us to sanity. . ."

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(1) AA believes that an alcoholic person is virtually insane while under the influence of alcohol.

(2) A major facet of overcoming this insanity is the belief in a force or power greater than self.

c. Step Three. ". . . made a decision to turn our will and our lives over to the care of God as we understand Him. . ."

(1) Prior to the alcoholic discontinuing his/her drinking, his/her management of life has usually been poor.

(2) AA believes that due to a record of poor life management on the alcoholic's part, he/she needs assistance from a power he/she considers greater than him/herself.

d. Step Four. ". . . made a searching and fearless moral inventory of ourselves. . ."

(1) It is suggested that a person make a written list of his/her strengths and weaknesses, based on various introspection.

(2) This list may take some members several years to complete, depending upon their readiness to face their moral selves.

e. Step Five. ". . . admitted to God, to ourselves, and to another human being the exact nature of our wrongs. . ."

(1) The list compiled in Step Four must then be shared with another person. This person need not be alcoholic. Some outlets are family members, religious ministers, or friends.

(2) The unburdening of past events to another person allows the alcoholic to vent accumulated feelings of guilt, remorse, and other unpleasant feelings the alcoholic may have carried for a long period of time.

f. Step Six. ". . . were entirely ready to have God remove all these defects of character. . ."

(1) After the alcoholic has confided his/her past with another person, he/she must than be willing to ask forgiveness of his/her past trangressions.

(2) This action then allows the person to start a new life away from the past.

g. Step Seven. ". . . humbly asked Him to remove our shortcomings. . ."

(1) The alcoholic comes to realize he/she is not perfect and does have faults.

(2) Again, he/she enjoins his/her higher power to remove his/her shortcomings, thus allowing the person to feel he/she is not combating insurmountable odds in life.

(3) This does not mean the alcoholic will no longer be responsible for living his/her own life. It simply reduces some of the personality obstacles the person has created.

h. Step Eight. ". . . made a list of all persons we had harmed and become willing to make amends to them all. . ." Like Step Four, this step requires the alcoholic to make another written list of all persons he/she can recall having harmed in any manner. The harm may have been physical or phycological.

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i. Step Nine. ". . . made direct amends to such people wherever possible, except when to do so would injure them or others. . ."

(1) This step is designed to relieve the guilt and resentment a person may still hold as a result of his/her negative actions.

(2) There are instances where such amends would be either physically or psychologically damaging to the alcoholic or the other party/parties concerned.

j. Step Ten. ". . . continued to take personal inventory and when we were wrong promptly admitted it. . ."

(1) This step is an ongoing maintenance step.

(2) After the major inventory in Step Four and the admission of past wrongs in Step Five, the alcoholic must then continue his/her moral research and admit to wrongdoings to limit the possibility of return to his/her previously unproductive life style.

k. Step Eleven. ". . . sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will and power to carry that out. . ." This step is designed to increase the alcoholic's spiritual program and strengthen his/her conviction that he/she is not alone in his/her fight for recovery.

l. Step Twelve. ". . . having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs. . ."

(1) One way alcoholics carry the message of AA is through twelve-step calls.

(2) A twelve-step call is simply going out to where a still drinking alcoholic is located and explaining how the program works and relating personal experiences. The twelve-step call is made only after the alcoholic calls for help.

2. Explain that the practice of the 12 steps of AA becomes a way of life. The steps may be "worked" many times over the course of the alcoholic's life.

APPLICATION/EVALUATION

1. Explain step one of AA.

2. Explain step three of AA.

PRESENTATION

6f. CRITERION OBJECTIVE: Identify the purpose and program of Al-Anon and Alateen.

1. Identify the purpose and program of Al-Anon.

a. Al-Anon is a fellowship of families and friends of alcoholics. The alcoholic who affects the Al-Anon member may be:

(1) drinking or in treatment.

(2) recovered with or without AA.

(3) or dead.

b. The purpose of Al-Anon is to provide emotional and spiritual support to the families and friends of alcoholics.

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(1) sharing the common problems of surviving in a home with an alcoholic.

(2) sharing experiences and solutions.

(3) education about alcohol, alcoholism, and how it affects family members.

(4) Out of this sharing, Al-Anon members believe "serenity of spirit" and enriched lives.

c. The Al-Anon program is designed to allow the spouse to reevaluate him/herself by emphasizing:

(1) The spouse cannot change the alcoholic.

(2) The spouse can change him/herself.

(3) The alcoholic must be accepted as he/she is. Efforts to reform the alcoholic detract from energies the spouse could use for him/herself.

(4) Playing "ain't it awful" about the alcoholic spouse hurts the Al-Anon member. The non-alcoholic spouse needs to do something more positive. Only through positive action will the Al-Anon begin to feel good about him/herself.

(5) The spouse is not responsible for the alcoholic's behavior and should not accept this responsibility. Accepting responsibility for the alcoholic perpetuates the alcoholic's disease.

(6) The spouse must learn to be more self-sufficient.

(a) This may mean that the marriage be dissolved, or

(b) The non-alcoholic spouse and children learn to reorganize their lives without the alcoholic spouse.

2. Identify the purpose and program of Alateen.

a. The purpose of Alateen is to provide information and emotional and spiritual support for the teenage children of alcoholics.

(1) Alateen is a part of Al-Anon, despite the fact that each group is self-supporting.

(2) An AA or Al-Anon member acts as advisor to group. The advisor does not participate in group unless asked to by group members.

b. Alateen group meetings are basically the same as Al-Anon meetings.

3. Explain that Al-Anon and Alateen groups can be valuable resources for social actions drug/alcohol specialists.

a. The Al-Anon and Alateen groups can provide the support and help your staff may not be able to provide the families of your clients.

b. By getting "well," the family may help in the recovery process of your clients to:

(1) Face his/her problem.

(2) Cease playing alocholic games that help perpetuate alcoholic behavior.

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c. Al-Anon and Alateen groups can be contacted through:

(1) phone directory.

(2) the nearest Al-Anon central office.

(3) the local council on alcoholism.

d. The families of your clients starting their own chapter. This has several advantages:

(1) convenience.

(2) commonality of AF experiences and interests.

(3) possible inclusion of families of abusers of other substances.

e. The procedure for starting a new chapter are:

(1) Decide on a meeting place.

(2) Write the Al-Anon Family Group Headquarters announcing the discussion to start a chapter. Headquarters will send the necessary literature to start and register the new group.

(3) The new group then elects officers and works out the details of their program.

f. Alcoholism is a family disease and Al-Anon and Alateen can help the "family" part of the disease.

APPLICATION/EVALUATION

1. What is the purpose of Al-Anon?

2. What is the purpose of Alateen?

3. How can Al-Anon or Alateen help the families of your clients?

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PRESENTATION

6g. CRITERION OBJECTIVE: Identify the ways in which USAF rehabilitation programs can incorporate Alcoholics Anonymous (AA) and AA principles, and the procedure for working through the first five AA steps.

1. Identify the ways in which USAF rehabilitation programs can incorporate Alcoholics Anonymous and AA principles.

a. Alcoholics Anonymous should generally be made a part of a recovering alcoholic regimen. The first way to incorporate AA is to have your client join a local AA chapter.

(1) AA works well for most, but exceptions should be noted:

(a) AA does not work for all, and so AA may not be a part of the regimen for some clients who do not respond to AA.

(b) Your local AA may not accept drug abusers, and/or may not "speak" or appeal to them.

(c) Your local AA may not appeal to younger alcoholics.

(d) AA may not be available locally.

(2) Even though you may suggest AA as part of the rehab regimen, you cannot require AA attendance, as there is no means of checking whether a person actually attended. To do so would violate AA principles.

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(3) If a client chooses to elect AA as part of his/her regimen, the knowledgeable counselor can monitor the client's

progress through the 12 AA steps, providing complementary support and helping the client deal with relevant issues in counseling.

b. The second way you can implement AA in your rehabilitation program is to start a chapter on base. You may want to do this if there are no suitable ones nearby, or simply because of convenience, or because of the common interests shared by Air Force people.

(1) Most bases have AA members who are willing to start on-base chapters.

(a) SLD AA members.

(b) Former rehabilitees.

(c) Dependents

(d) DAF civilians.

(e) AF members who are AA members, but who were not formally entered in the USAF rehab program.

(2) AA members are a valuable volunteer asset to initiate an AA group.

(a) Sharing their experiences as an alcoholic, and an AA member.

(b) Sponsoring new AA members.

(3) On-base groups have the following advantages:

(a) Convenience.

(b) Commonality of AF experiences and interests.

(c) Easy inclusion of social actions drug/alcohol specialists.

(d) Possible inclusion of abusers of other substances more readily than off-base chapters.

c. The third way to incorporate AA is to use AA principles in social actions counseling.

(a) This occurs, especially, where a suitable AA group does not exist, and it is not advantageous to start one.

(b) Requires SL personnel to be thoroughly familiar with AA and AA principles.

(c) SLD specialist uses the AA step approach to rehabilitation in SLD group counseling.

(d) You will need a chaplain to work the fourth and fifth step. This involves admitting to another past incidents which may cause legal complications unless that person has priviledged communication.

(e) The fourth way to incorporate AA in your USAF rehabilitation program is any combination of the three above methods.

2. Identify the procedure for working through the first five AA steps. In rehabilitation, usually the client is working only the first five steps, with emphasis on step 1.

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a. STEP ONE. "We admit we are powerless over alcohol and that our lives have become unmanageable."

(1) The major goal of Step One is to have the client recognize that alcohol has been destroying his/her life and to accept treatment. This can be very difficult because of the denial alibi system that alcoholics develop.

(2) Identify the procedures for working Step One:

(a) Educate the client concerning:

1. The disease concept of alcoholism, and how alcoholism has affected persons lives; give specific examples.

2. The principles and mechanics of AA.

(b) Have the client observe others go through their first step.

(c) Have the client make a list of all destructive behaviors related to his/her alcoholism. The list should include:

1. The person's progressive decline in life manageability.

2. Specific incidents, circumstances, and feelings involved.

3. An indication of the person's powerlessness over alcohol.

(d) Have the client read the list to the group. The group does not respond immediately.

(e) Group gives feedback to the client in the following areas:

1. Evidence of unmanageability.

2. Progressive decline of behavior.

3. Feelings expressed.

4. Incongruent behavior and statements.

(f) Do not permit client to justify any behavior. The client just listens to the feedback.

(g) Rework Step 1, or parts of Step 1, if necessary based on the group feedback.

b. STEPS TWO AND THREE. Step Two: "We came to believe that a Power greater than ourselves could restore us to sanity." Step Three: "We made a decision to turn our will and our lives over to the care of God as we understand Him."

(1) The major goals of Steps Two and Three are to achieve faith that things can be changed; that there is a power greater than the alcoholic alone; and that power will help the alcoholic through this bad time.

(2) Identify the procedures for Steps Two and Three:

(a) Clarify God vs faith.

1. For clients with a strong religious background this can mean drawing strength on beliefs already held or reclaiming those denied or forgotten.

2. For clients without religious beliefs, the Power can mean the power that comes from seeing other people use the rehab program and get control over their lives. It can mean turning their lives over to a rehab regimen; placing faith in the healing power of the group; of the good will in people; etc.

3. Allow clients to listen to the experiences of other group members on what and how their "higher" powers have helped them. This will help the client clarify what he/she believes and is willing to put faith in.

4. Avoid theological discussions. Allow the client to interpret his/her "Higher" power and how it works.

(b) Clarify the AA view of compliance, acceptance, and surrender in alcoholism.

1. Compliance is following the rules without any commitment to what is being done. Alcoholics will sometimes see this as acceptance.

2. Acceptance is the intellectual and emotional belief that alcohol is the cause of life problems.

3. Surrender involves accepting that alcohol has caused life problems and then completely giving up alcohol. Surrender means action.

(c) The counselor should work with the client in counseling on acceptance of the power of alcohol and the need to give it up.

c. Step 4: "Made a searching and fearless moral inventory of ourselves."

(1) The major goal of Step 4 is for the client to become aware of his/her character defects and assets. The goal can be expressed in the statement, "Know thyself."

(2) Identify the procedures for Step 4.

(a) Clarify the meaning of moral inventory.

1. Based on client's values, standards, beliefs, principles, and ethics.

2. Can be broken into two areas: liabilities (weaknesses) and assets (strengths). Some examples are:

ASSETS	LIABILITIES
honest	dishonest
loyal	self righteous
patient	impatient
kind	arrogant
trustworthy	selfish
sense of humor	resentful

3. Other group members can help by giving examples from or presenting their inventories.

(b) Have clients make their inventory.

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1. It is best to have client list liabilities first and wait about a week before listing assets.

2. This helps prevent "minimizing" by the client.

(c) The fourth step can be very emotional.

1. The fourth step should be given to one-on-one counseling not in group.

2. It would be helpful if the chaplain listened to the fourth step work.

(d) After presenting the fourth step work to the counselor, the client may need to go back and rework the inventory before going on to Step 5.

d. Step 5: "Admitted to God, to ourselves and to another human being the exact nature of our wrongs."

(1) The major goal of step 5 is for the client to gain true awareness and acceptance of him/herself by expressing the guilt and the shame to another human being.

(2) Identify the procedures for Step 5.

(a) Step 5 should be very specific. To do this it can be broken into three parts: behavior (incident) attitude and feelings. In the example of the man who stole money from his wife.

1. He would first tell what he did (his behavior).

2. The client would then relate his attitude at the time about what he was doing, "I'll put it back tomorrow, besides I worked for this money." The

attitude at the time may be his rationalization for doing the behavior.

3. The client then relates how he felt, "Since I never put the money back, I tried to convince myself that it was okay. But underneath I felt rotten about myself."

(b) A chaplain or someone with legal immunity should listen to step 5, since it may involve past crimes. This applies as well to items of an illegal nature that may be on the step 4 inventory.

1. The person listening to step 5 must be non-judgemental and understanding.

2. After the client has given step 5 it is important to stroke the client for being strong enough to survive, and strong enough to be honest. Stroke the client also for being willing to share all the bad things that have happened with another person.

3. The client may not finish all of step 5 in one session. It may take several sessions or weeks to complete this step.

3. Explain that the 12 steps is a continuing growth process that may be repeated over and over.

a. Many clients may finish step 5 and realize they did an incomplete step 1 or step 4.

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b. The client may want to go back and complete the steps that may have been incomplete.

c. This can enable the client to continue growing and evaluating his/her feelings, attitude and behavior.

d. This continuous growth process may help your clients maintain their sobriety.

e. Chances are that as they are more honest with themselves and others, and they find they are not rejected, they will develop a more positive self image.

f. This positive self image is necessary to reverse the negative cycle they have become caught in.

g. Even as the negative cycle "snowballs" so will the positive cycle. It's important for you, the counselor, to help the client start the positive cycle and keep it going.

APPLICATION/EVALUATION

1. What are some of the advantages of on base AA groups?

2. What is the most difficult step of the 12 steps of AA? Why?

3. What is the major goal of step 1?

4. What is the major goal of step 4?

5. What is the major goal of step 5?

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CONCLUSION (10 minutes)

SUMMARY

1. Restate the lesson objectives and highlight the main points:

a. The requirements for entry into the Air Force, centralized alcohol rehabilitation program.

b. The approach of the centralized rehabilitation program and the primary program elements.

c. The roles of aversion therapy, antabuse treatment, therapeutic communities and private rehabilitation centers in alcohol rehabilitation.

d. The 12 step of AA and how they work.

e. The purpose of Al-Anon and Alateen and how they can be used.

f. The ways AA principles can be incorporated into the AF rehabilitation program.

REMOTIVATION/CLOSURE

You are not alone in offering help beneficial to the alcoholic or the family of the alcoholic. You should not try to carry the burden of all rehabilitees.

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Your responsibility as a Drug/Alcohol specialist is to see that all alcoholics and their families on your base are afforded help which they are able to use.

To get them this kind of help involves your being familiar with the wide range of alcohol rehabilitation models available to assist them depending on their individual needs.

Some alcoholics are best rehabilitated in your local programs, others best in the USAF Alcohol Treatment Centers, others in AA, others in private centers or a combination of these. It is up to you and the rehab committee to recommend the most appropriate modality.

Your knowledge of these models, and particularly how to integrate AA into your local programs will help you make effective recommendations for your clients and emphasize the key elements of AA in individual and group counseling.

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STUDY GUIDE

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Technical Training

Drug and Alcohol Abuse Control

Program Management

ALCOHOL REHABILITATION MODELS

15 June 1978

HEADQUARTERS 3250 TECHNICAL TRAINING WING (ATC)
(USAF Technical Training School)
Lackland Air Force Base, Texas

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Social Actions Training Branch
Lackland Air Force Base, Texas

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15 June 1978

Program Management

ALCOHOL REHABILITATION MODELS

OBJECTIVE

Upon completion of this unit of instruction you will be able to identify the entry requirements and treatment approaches for the centralized alcohol rehabilitation program, the concepts of therapeutic communities and private rehabilitation centers, Alcoholics Anonymous (AA), and Al-Anon, and how to use AA and Al-Anon in your base-level program.

INTRODUCTION

With more federal money, federal encouragement and national interest in alcoholism emerging, the attitude toward treatment of alcoholism is changing and rehabilitation responsibilities are being channeled in a productive direction. Rehabilitation of the alcoholic person is now centered around physicians, therapists, and medical technicians, as well as psychiatrists, social workers, and mental health personnel. No longer should the alcoholic or alcohol abuser get caught in the revolving door of the "system"; i.e., caught speeding and driving while intoxicated (DWI), or arrested for public drunkenness, dumped into the drunk tank to sleep in his/her own vomit, and then released after one or two days, back on the street, drinking again; a cyclic operation getting nothing accomplished, as far as rehabilitation is concerned.

Social Actions personnel can be agents for change to the existing revolving-door system. Rehabilitation of at least half of the 9 million alcoholics or alcohol abusers *is* possible. Along with that will come the saving of 7 to 8 billion dollars. As the catalyst, you can pull hard in your direction to change attitudes of base personnel who think rehabilitation efforts are a waste of their time and money. Since the federal government is supporting the program now with several-hundred-thousand dollars, a lot more "punch" is available to you.

With the emphasis, then, on alcohol rehabilitation, what resources are available for extended rehabilitation efforts beyond base level, or for referral of Department of the Air Force (DAF) civilian employees or dependents? The following information will be of assistance in expanding or improving rehabilitation efforts.

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Supersedes SG B-IV-6-12, 25 April 1977.

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ENTRY REQUIREMENTS FOR CENTRALIZED REHABILITATION

Base-level or local rehabilitation is an effort coordinated among supervisors, commanders, chaplains, medical personnel, and Social Actions. Centralized rehabilitation, however, is under the Surgeon General as office of primary responsibility (OPR), and governed by Air Force Regulation (AFR) 160-86, *Rehabilitation of Personnel with Drinking Problems.* This regulation lists the unit locations, entry requirements, and guidelines for operations. There are presently two major types of centralized rehabilitation programs: the 28-day program and the 14-day aversion program. The 28-day programs are located at:

- Andrews AFB, Maryland.
- Clark AB, Philippines.
- Eglin AFB, Florida.
- Lackland AFB, Texas.
- Lakenheath AB, England.
- Scott AFB, Illinois.
- Travis AFB, California.
- Weisbaden AB, Germany.
- Wright-Patterson AFB, Ohio.

There are two 14-day aversion therapy treatment centers:

- Sheppard AFB, Texas, and
- Clark AB, Philippines.

(NOTE: Clark AB has both programs.)

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Referral

The rehabilitation committee makes the referrals for centralized rehabilitation. Treatment at a central rehabilitation center is normally used only when local medical and nonmedical resources are limited. Each referral request to a center must be accompanied by a detailed

summary outlining the efforts undertaken at the local level and the results thereof, together with all other pertinent data. The rehabilitation committee takes all individual factors into account when making its recommendation.

Detoxification

The alcoholic must be detoxified locally (for up to 10 days) prior to acceptance at the treatment center. The treatment center is designed for rehabilitation, not for detoxification. The individual travels in a patient status, usually via aeroevacuation. If detoxification facilities are unavailable at an installation, the individual may be medically evacuated to a base where the capabilities exist. An example of this procedure would be med-evacuating a patient from Sheyma Air Station (AS), Alaska, to Elmendorf AFB, Alaska, for detoxification, then entry into the centralized rehabilitation center at Travis AFB, California.

Responsibility

VOLUNTEER OR NONVOLUNTEER. The alcoholic may be a volunteer or mandatorily entered. Administration of patient removal becomes a medical service responsibility, including arrangement for others, aeroevacuation, and actual patient movement.

THE CENTRALIZED REHABILITATION PROGRAM

AFR 160-36 covers the Centralized Rehabilitation Program. Social Actions drug/alcohol specialists need to know how the treatment centers operate in order to prepare their clients, and so that they (the specialists) can relate to what has happened to their clients while they were attending centralized rehabilitation.

Group Living

The group lives in a separate hospital ward to promote feelings of acceptance, belonging, security, equality, and self-image. The community-living approach requires that the members

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remain alcohol-free and attend all programed activities. The structured lifestyle in which the members live provides a safe environment where change can occur.

Individual Counseling

The average patient population is ten to fifteen at any given time. There are counselors, a medical doctor, psychologists, and psychiatric social workers available on a 24-hour-a-day basis. Individual counseling is normally done on an as needed basis.

Education

A series of lectures, films, and video tapes are given to the group on the harmful psychological/physiological effects of alcohol. A presentation is made by a professional who expands on the medical aspects of alcohol abuse and alcoholism.

Group Therapy

Group therapy is the preferred counseling technique. Group therapy includes confrontation, Gestalt, and psycho-drama. Groups meet once or twice daily throughout the week.

Alcoholics Anonymous

Patients are required to attend an AA lecture, where the AA program is presented to them. AA meetings in the local community are offered to the patients on a biweekly basis. Transportation to and from the meetings is provided.

Recreational and Occupational Therapy

During recreational therapy, patients are required to participate in exercise such as volleyball, weight lifting, running, etc. Occupational therapy includes such activities as leatherwork, ceramics, string art, etc.

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OTHER APPROACHES

There are a number of alcohol treatment approaches available to drug/alcohol specialists. In order to make the most effective recommendation for your clients, you need to be aware of the other approaches.

Aversion Therapy

The aversion therapy model is available in civilian communities and in the Sheppard AFB and Clark AB treatment centers. This theory views the concept of alcoholism as a learned behavior and, therefore, treatment is oriented toward changing the behavior. One method of aversion therapy allows the alcoholic all the alcohol he/she wants of his/her favorite brand in a "Duffy's Tavern" environment. When the normal desire is satisfied, still more is given, until the person gets sick and vomits. This is continued several times a day under controlled conditions until, hopefully, the person develops an aversion to drinking. The second method, electric shock, delivers a mild electric shock to the drinker just as he/she is about to drink. The same objective exists for this method as aversion therapy — to get the person to develop an aversion to drinking, through association.

Antabuse Treatment

Administering the drug antabuse orally will cause almost immediate illness to the person once alcohol is mixed. Reactions could include flushing, palpitations, hyperventilation, nausea and, in some cases, unconsciousness, just to name a few. Antabuse must be administered by medical personnel and under controlled doses, for its use could possibly be dangerous. It should never be given to an intoxicated person, and administration of the drug should not begin until the person has at least 12 alcohol-free hours. Violent illness is to be expected if antabuse is not properly administered. The effects of antabuse normally last from 24 to 96 hours. However the effects can last up to 10 days depending on how long the individual has been taking antabuse.

Antabuse critics sometimes label its use as a "crutch," or an easy way out to keep from drinking. A reply to such a critic could be, "If someone is crippled and wants to learn to walk again, what's wrong with a crutch?"

Therapeutic Community

Established on the same model as the drug rehabilitation therapeutic community model, alcohol recovery houses have grown up in some cities. The elements of this model are not on one person doing all treatment, but a group of alcoholics who have experienced similar problems working together to help each other. Of course, specialists are available and assist in the efforts; but, primarily, the responsibility is with the alcoholic accepting responsibility for his/her own life and changes, and working toward his/her self-established goals with help from fellow alcoholic patients.

Private Centers

Designed and catering primarily to the middle- and upper-income classes, are those centers privately supported by the patients. The environment is a country-club, comfortable, almost plush atmosphere, with highly-trained staff and adequate medical facilities. A multitude of recreation facilities are available, as well as counseling opportunities, both individual and group. In addition, family therapy is offered for those nonalcoholic members of the family. An example of this model is La Hacienda, a rehabilitation center in the scenic hill country near Kerrville, Texas. It's located on the Guadalupe River, providing a comfortable, relaxing atmosphere, including fishing and boating opportunities. The cost is around $3,500 for 14 days' residency. The treatment available here and at most hospitals or other centers is gradually being approved to be covered by some insurance companies, as well as the Civilian Health Medical Program of the Uniformed Services (CHAMPUS).

ALCOHOLICS ANONYMOUS

Probably the oldest of the organized treatment modalities, and considered by some professionals to be the most successful so far as rehabilitation efforts are concerned, is the AA model. This model, like the other ones, is not *the* answer for everyone; but, its existence and success rate alone are enough to consider. The program was founded in 1935 by a small number of professional people who were alcoholic. Today, there are more than 600,000 persons involved, but the exact number will never be known, due to the anonymity position. Membership records are not kept, and formal organizational structure is virtually nonexistent. Each chapter is anonymous and, through self-supporting efforts, maintains

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a place to meet (rent), provides donations to national programs, and provides refreshments at local meetings. The only requirement for membership in AA is very appealing — possession of the desire to stop drinking.

Basic Position

The AA position on alcoholism is that alcoholism can be arrested; it is treatable; and alcoholics can be restored. Its basic approach is through fellowship of men and women sharing experiences, strengths, and hopes; with the goal of solving their common problem, and helping others recover from alcoholism.

Ultimate Goal

AA has as its ultimate goal the arresting of alcoholism through total abstinence from alcohol. According to AA, alcoholism cannot be cured in the ordinary sense of the term, but it can be arrested. The fellowship's sole concern is to maintain sobriety and to help others achieve it.

Primary Recovery Method

The primary method for recovery in AA is the Twelve Steps. A sponsor (recovering alcoholic) shares his/her story with a newcomer. The sponsor shares his/her sobriety efforts and then invites the newcomer to open the chapter or another chapter, in the local area. The newcomer usually identifies with the sponsor's story and shares his/her problem. As the newcomer begins to feel acceptance, he/she begins to respond to the concern.

THE TWELVE STEPS OF AA

Drug/alcohol specialists need to know the Twelve Steps in order to explain and help their clients understand them.

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The following "Twelve Steps of AA" are explained according to the book, *Alcoholics Anonymous*, and the *Twelve Steps* and *Twelve Traditions*.

Step One

". . . We admitted we were powerless over alcohol — that our lives had become unmanageable. . . ." For a person to admit that he/she is powerless is a difficult decision, but it is an essential component of recovery. The unmanageability comes in various forms — financial, moral, and spiritual. The first step is considered the most important, because it is the point where the alcoholic makes a decision to stop drinking and work a program of recovery.

Step Two

". . . came to believe that a Power greater than ourselves could restore us to sanity. . . ." AA believes that an alcoholic person is virtually insane while under the influence of alcohol. A major facet of overcoming this insanity is the belief in a force or power greater than self.

Step Three

". . . made a decision to turn our will and our lives over to the care of God as we understand Him. . . ." Prior to the alcoholic discontinuing his/her drinking, his/her management of life has usually been poor. AA believes that due to a record of poor life management on the alcoholic's part, he/she needs assistance from a power he/she considers greater than himself/herself. Alcoholics must resign themselves to the fact that they do have difficulty in living life and must turn all aspects of their lives over to that power which they consider greater than themselves. The power greater than self is unique to each alcoholic, because it is not defined. It is only what the person perceives it to be. This power takes as many forms as there are individuals; i.e., some people refer to it as God. For others, it has been the AA group, family groups, or other form of outside influence.

Step Four

". . . made a searching and fearless moral inventory of ourselves. . . ." It is suggested that a person make a written list of his/her strengths and weaknesses, based on various introspection. This list may take some members several years to complete, depending upon their readiness to face their moral selves.

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Step Five

". . . admitted to God, to ourselves, and to another human being the exact nature of our wrongs. . . ." The list compiled in Step Four must then be shared with another person. This person need not be alcoholic. Some outlets are family members, religious ministers, or friends. The unburdening of past events to another person allows the alcoholic to vent accumulated feelings of guilt, remorse, and other unpleasant feelings the alcoholic may have carried for a long period of time.

Step Six

". . . were entirely ready to have God remove all these defects of character. . . ." After the alcoholic has confided his/her past with another person, he/she must then be willing to ask his/her higher power to forgive his/her past transgressions. This action then allows the person to start a new life away from the past.

Step Seven

". . . humbly asked Him to remove our shortcomings. . . ." The alcoholic comes to realize he/she is not perfect and does have faults. Again, he/she enjoins his/her higher power to remove his/her shortcomings, thus allowing the person to feel he/she is not combating insurmountable odds in life. This does not mean the alcoholic will no longer be responsible for living his/her own life. It simply reduces some of the personality obstacles the person has created.

Step Eight

". . . made a list of all persons we had harmed and became willing to make amends to them all. . . ." Like Step Four, this step requires the alcoholic to make another written list of all persons he/she can recall having harmed in any manner. The harm may have been physical or psychological.

Step Nine

". . . made direct amends to such people wherever possible, except when to do so would injure them or others. . . ." This step is designed to relieve the guilt and resentment a person may still hold as a result of his/her negative actions. There are instances where such amends would be either physically or psychologically damaging to the alcoholic or the other party/parties concerned.

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Step Ten

". . . continued to take personal inventory and when we were wrong promptly admitted it. . . ." This step is an ongoing maintenance step. After the major inventory in Step Four and the admission of past wrongs in Step Five, the alcoholic must then continue his/her moral research and admit to wrongdoings to limit the possibility of return to his/her previously unproductive life style.

Step Eleven

". . . sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will and power to carry that out. . . ." This step is designed to increase the alcoholic's spiritual program and strengthen his/her conviction that he/she is not alone in his/her fight for recovery.

Step Twelve

". . . having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs. . . ." One way alcoholics carry the message of AA is through twelve-step calls. A twelve-step call is simply going out to where a still-drinking alcoholic is located and explaining how the program works and relating personal experiences. The twelve-step call is made only after the alcoholic calls for help. The practice of the AA principles becomes a way of life on a daily basis. The steps may be worked many times over the course of the alcoholic's life.

THE TWELVE TRADITIONS

"The Twelve Traditions of AA" are guidelines to the operation and structure of AA. The Traditions are designed to keep AA a separate and unique organization, dedicated to the sole purpose of helping alcoholics find and maintain sobriety.

Tradition One

"Our common welfare should come first; personal recovery depends on AA unity." This tradition places the individual within the structure of the group and requires that all members strive together for the common well-being of the group.

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Tradition Two

"For our group purpose there is but one ultimate authority — a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern." AA relies on the concept of a higher power as the governing agent of the group. The formal leadership aspect is kept at the lowest level possible for the common welfare of the group. Each member is considered equal, no matter how much sobriety he/she possesses. To keep this balance of equality, positions of authority are minimized.

Tradition Three

"The only requirement for AA membership is a desire to stop drinking." AA will accept any member who wishes to stop drinking into its ranks. The person need not have actually stopped his/her consumption of alcohol. If the person wants to stop and is willing to attempt quitting, he/she is eligible for AA membership.

Tradition Four

"Each group should be autonomous except in matters affecting other groups or AA as a whole." Each group has its own identity and activity format which are unique to itself. Each group then is free to keep its individuality, unless its functioning or beliefs infringe on the welfare of other groups or the overall structure of AA.

Tradition Five

"Each group has but one primary purpose — to carry its message to the alcoholic who still suffers." Through the use of group meetings and twelve-step calls, AA carries the message to the still-drinking alcoholic. AA does not seek out the sick alcoholic, but responds only when that person makes a call for help.

Tradition Six

"An AA group ought never endorse, finance, or lend the AA name to any related facility or outside enterprise, lest problems of money, property, or prestige divert us from our primary purpose." The sole function of AA is facilitating the recovery of the alcoholic. Any other involvement in any unrelated activity might endanger the purpose of the organization of AA.

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Tradition Seven

"Every AA group ought to be self-supporting, declining outside contributions." Each group finances its existence through voluntary collections at AA meetings. AA will not accept large contributions from external sources or from any of its members.

Tradition Eight

"Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers." AA does not hire or maintain medical or psychiatric personnel or any other professional person or group. The special workers who are employed work for small salaries and do solely AA work.

Tradition Nine

"AA, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve." The concept of formal organizational structure is not used in AA, but special working groups may be formed to accomplish varied tasks. These working groups directly serve the persons who initiated them.

Tradition Ten

"Alcoholics Anonymous has no opinion on outside issues; hence, the AA name ought never be drawn into public controversy." The execution of the primary purpose of helping alcoholics recover is AA's only concern. The involvement of AA in unrelated issues might prove detrimental to this end.

Tradition Eleven

"Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films." Rarely will an AA member make a public appearance through the use of media. If such appearances are made, the member must protect his/her identity as much as possible. The idea of promoting the program of AA has, in the past, proved detrimental to the primary purpose of AA.

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Tradition Twelve

"Anonymity is the spiritual foundation of our traditions, ever reminding us to place principles before personalities." The idea that each alcoholic is equal deglamorizes personalities and encourages members to focus in on the AA principles as a way of life.

MEETINGS

AA meetings include two types: open, for family and friends of the alcoholic, and for anyone who is having a drinking problem and wants to do something about it; and, closed, limited to AA members only.

AL-ANON AND ALATEEN

Al-Anon and Alateen groups can be a valuable resource for drug/alcohol specialists. The groups can provide the support and help your staff may not be able to provide the families of your clients.

Al-Anon

Al-Anon is a fellowship for families and friends of alcoholics, similar in structure, program, and philosophy to Alcoholics Anonymous. The alcoholic who affects the Al-Anon member may be

- drinking or in treatment.
- recovered with or without AA.
- dead.

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The purpose of Al-Anon is to provide emotional and spiritual support to the families and friends of alcoholics. This is done through:

SHARING COMMON PROBLEMS. Nonalcoholics living with an alcoholic may think no one else has the same kinds of problems. Al-Anon emphasizes that the nonalcoholic is not alone and that others have had similar problems and feelings.

SHARING EXPERIENCES. By sharing experiences, Al-Anon members help each other understand and sometimes solve the problems of living with an alcoholic.

EDUCATION. Al-Anon offers education on the nature of alcoholism, as well as the role the nonalcoholic plays in alcoholism.

The Al-Anon program uses the Twelve Steps of AA with one change. In Step Twelve, the word "others" replaces "alcoholics." The program is designed to allow the nonalcoholic to reevaluate his/her life with an alcoholic by emphasizing:

AL-ANON CANNOT CHANGE THE ALCOHOLIC. Al-Anon helps the nonalcoholic understand that he/she cannot change the alcoholic and that continued efforts in that direction are useless. Al-Anon also emphasizes that, while the nonalcoholic cannot change the alcoholic, he/she can change himself/herself.

ACCEPTANCE. The alcoholic must be accepted as he/she is, and efforts to reform the alcoholic detract from energies the spouse could use for himself/herself.

INDEPENDENCE. The nonalcoholic must learn to be self-sufficient. This may mean that the nonalcoholic reorganizes his/her life without the alcoholic.

Alateen

Alateen is a fellowship for the teenaged (12 – 21) children of alcoholics.

The purpose of Alateen is to provide information, and emotional and spiritual support to its members.

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Alateen groups use the same Twelve Steps of Al-Anon. While Alateen is a part of Al-Anon, each group is self-sufficient.

USING AL-ANON AND ALATEEN

Use of Al-Anon and Alateen by Social Actions Drug/Alcohol specialists can provide advantages by:

- providing support for families of your clients.
- helping the families "get well," therefore helping the recovery process of your clients.

Contacting Al-Anon and Alateen

Al-Anon and Alateen can be contacted several ways.

- Phone directory
- Nearest Al-Anon Central office
- Local council on alcoholism

Starting an Al-Anon or Alateen Group

If there is no group near, the families of your clients may want to start a group on base. This has several advantages:

- Convenience.
- Commonality of AF experiences and interests.
- Possible inclusion of families of other substance abusers.

PROCEDURE. The procedures for starting a group are simple.

- Decide on a meeting place.
- Write the Al-Anon Family Group Headquarters, announcing the decision to start a group, and they will send you the necessary literature.
- Elect officers.

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ALCOHOLICS ANONYMOUS AND THE USAF REHABILITATION PROGRAM

Alcoholics Anonymous should generally be made a part of a recovering alcoholic's regimen.

INCORPORATING AA

There are three ways AA can be incorporated into the USAF Rehabilitation Program. They are:

Have Client Join Local AA Chapter

The knowledgeable counselor can monitor the client's progress through the Twelve Steps, providing complementary support, and helping the client deal with relevant issues in counseling.

Start a Chapter on Base

If there are no suitable chapters nearby, you may want to start a chapter on base. Most bases have AA members who are willing to start on-base chapters, such as:

SLD AA members,

former rehabilitees,

dependents,

DAF civilians,

AF members who are AA members, but who are not formally entered in the USAF Rehabilitation Program.

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On-base groups have the following advantages:

Convenience,

Commonality of AF experiences and interests,

Easy inclusion of Social Actions Drug/Alcohol specialists,

Possible inclusion of abusers of other substances more readily than off-base chapters.

Use AA Principles in Drug/Alcohol Counseling

This occurs especially where a suitable AA group does not exist, and it is not advantageous to start one. It requires that the drug/alcohol specialist be thoroughly familiar with AA and AA principles. If this approach is used, it is best to have a chaplain who is familiar with, or willing to learn, the AA principles, and work with the group.

PROCEDURES FOR WORKING THE FIRST FIVE STEPS OF AA

The Social Actions Drug/Alcohol specialist uses the AA Step approach to rehabilitation in SLD group counseling. Only the first five steps are "worked" in group.

Step One

". . . We admitted we were powerless over alcohol — that our lives had become unmanageable. . . ."

MAJOR GOAL. The major goal of Step One is to have the client recognize that alcohol has been destroying his/her life and to accept treatment. This can be very difficult because of the denial/alibi system that alcoholics develop.

PROCEDURES. The procedures for working Step One are:

Education. The client will probably need more education on the disease concept of alcoholism, and how alcoholism has affected his/her life, and the principles and mechanics of AA.

Observation. It would help the client to have him/her observe others go through their first steps.

Make List. Have the client make a list of all destructive behaviors related to his/her alcoholism. (See Attachment 1.) This list should include:

progressive decline in life manageability;

specific incidents, circumstances, and the feelings involved; and

indications of the person's powerlessness over alcohol.

Present to Group. Have the client present the list to the group. The group then gives feedback to the client in the following areas:

Evidence of unmanageability,

Progressive decline of behavior,

Feelings expressed, and

Incongruent behavior and statements.

Rework. It may be necessary for the client to go back and rework Step One before going on.

Steps Two and Three

Step Two — ". . . came to believe that a Power greater than ourselves could restore us to sanity. . . ."

Step Three — ". . . made a decision to turn our will and our lives over to the care of God as we understand Him. . . ."

MAJOR GOAL. The major goals of Steps Two and Three are for the client to achieve faith that his/her life can be changed; that there is a Power greater than the alcoholic alone; and that Power will help the alcoholic through this bad time.

PROCEDURES. The procedures for working Steps Two and Three are:

Clarify God vs. Faith. For clients with a strong religious background, this can mean drawing strength from beliefs already held, or reclaiming those denied or forgotten. For clients without a religious belief, the Power can mean the power that comes from seeing other people use the rehabilitation program and reclaim control over their lives. It can mean turning their lives over to a rehabilitation regimen; placing faith in the healing power of the group; of the goodwill in people; etc. Avoid theological discussions and allow the client to interpret his/her "higher" Power and how it works.

Clarify the AA View of Compliance, Acceptance, and Surrender in Alcoholism.

Compliance. Compliance is following the rules without commitment to what is being done. Alcoholics will sometimes see this as acceptance.

Acceptance. Acceptance is the *intellectual* and *emotional* belief that alcohol is the cause of life problems.

Surrender. Surrender involves accepting that alcohol has caused life problems, and then completely giving up alcohol. *Surrender involves action.*

The counselor should work with the client in counseling on acceptance of the power of alcohol and the need to give it up.

Step Four

". . . made a searching and fearless moral inventory of ourselves. . . ."

MAJOR GOAL. The major goal of Step Four is for the client to become aware of his/her character defects and assets. The goal can be expressed in the statement "Know thyself."

PROCEDURES. The procedures for working Step Four are:

Clarify Meaning of Moral Inventory. The moral inventory is based on the *client's* values, standards, beliefs, principles, and ethics, and can be broken into two areas: liabilities (weaknesses) and assets (strengths).

Some examples are:

LIABILITIES	ASSETS
dishonest	honest
self-righteous	sense of humor
impatient	loyal
arrogant	patient
selfish	trustworthy

Make Inventory. Have the client make his/her inventory. It is best to have client list liabilities first, and wait about a week before listing assets. This helps prevent minimizing by the client.

Present Inventory. The Fourth Step should be given in one-on-one counseling rather than in group. Fourth Step work can be very emotional and demanding for the client and it may be helpful if the chaplain listened.

Rework. After presenting the Fourth Step work to the counselor, the client may need to go back and rework the inventory. Step Four may take weeks to complete.

Step Five

". . . admitted to God, to ourselves, and to another human being the exact nature of our wrongs. . . ."

MAJOR GOAL. The major goal of Step Five is for the client to gain true awareness and acceptance of himself/herself by expressing the guilt and shame to another human being.

PROCEDURES. The procedures for working Step Five are:

Make List of Wrongs. The client should make a very specific list of the wrongs he/she has committed. This can be broken into three parts: behavior (incident), attitude, and feelings. In the example of the man who stole money from his wife:

The client would first tell what he did (his *behavior*).

The client would then relate his *attitude* at the time about what he was doing ("I'll put it back tomorrow."). The attitude at the time may be his rationalization.

The client then relates *how he felt* ("Since I never put the money back, I tried to convince myself that it was okay, but underneath, I felt rotten about myself.").

Present List. A chaplain or someone with legal immunity should listen to Step Five, since it may involve past crimes. This applies as well to items of an illegal nature that may be on the Step Four inventory. Whoever listens *must* be *nonjudgmental and understanding.*

Stroke the Client. After the client has given Step Five, it is important to stroke the client for being strong enough to survive, for being honest, and willing to share all the bad things that have happened.

The client may not finish all of Step Five in one session. It may take several sessions or weeks to complete this step.

SUMMARY

This study guide has covered the following:

The requirements for entry into the AF Centralized Alcohol Rehabilitation Program.

The approach of the Centralized Rehabilitation Program and the primary program elements.

The roles of aversion therapy, antabuse treatment, therapeutic communities, and private rehabilitation centers in alcohol rehabilitation.

The Twelve Steps of AA and how they work.

The purpose and programs of Al-Anon and Alateen.

The ways AA. principles can be incorporated into the AF Rehabilitation Program.

Your responsibility as a Drug/Alcohol specialist is to see that all alcoholics and their families, on your base, are afforded the help they need. To get this kind of help involves your being familiar with the wide range of alcohol rehabilitation models available to assist them, depending on their individual needs. Your knowledge of these models, and particularly how to integrate AA into your local programs will help you make effective recommendations.

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FIRST-STEP PREPARATION

The First Step of Alcoholics Anonymous:

"We admitted we were powerless over alcohol — that our lives had become unmanageable."

It would be impossible to overestimate the importance of the First Step, because treatment and recovery are impossible until the client accepts the seriousness and totality of the illness. Each client is required to make a list of destructive behaviors caused by his or her:

1. powerlessness over mood-altering chemicals, and
2. unmanageable life.

Areas in which powerlessness and unmanageability are often demonstrated by the chemically dependent are given below to assist you in preparing for the First Step.

- Preoccupation with chemicals.
- Attempts to control use of chemicals.
- Kinds, amounts, and frequency of use of chemicals.
- Effects on physical health.
- Effects on sexuality and sex life.
- Effects on emotional life or feelings.
- Effects on social life and friends.
- Effects on family.
- Effects on spiritual life.
- Effects on your work.
- Effects on finances.
- Effects on your character.
- Insane behavior, loss of memory, blackouts, etc.
- Destructive behavior against one's self and against others.
- Accidents caused by, and other dangerous situations produced by, the use of chemicals.

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WHAT AA MEETINGS TAUGHT A NON-AA COUNSELOR

Personal growth and help for clients come from participating in the AA experience

In late 1971, while I was working in the Air Force's drug abuse program, it became apparent that I needed to learn more about our number one drug of abuse, alcohol, and dependency on it, alcoholism. A friend suggested open AA meetings as a source of education. I attended my first meeting shortly thereafter and have continued to go ever since. These are some measurable benefits I have derived:

Discovering our common humanity: From the first meeting I felt a sense of identity with many of the speakers I heard, I began to say then, and have said many times thereafter, "I've never had any serious problem related to alcohol, but there's a lot of alcoholic in me." I said that because the alcoholics' concerns with ego, anger, frustration, manipulation, and fears of inadequacy sounded a lot like mine. Hearing how they dealt with them became more than an academic interest.

An AA friend in Colorado put it in perspective for me when he said, "Lee, what you have discovered is your common humanity with the alcoholic. There's probably no more alcoholic in you than in anyone else; but you've learned that between you and the alcoholic, there are more similarities than differences." Discovering and exploring our common characteristics, strong and weak, have been good for me and for my relationships with clients.

The vicarious experiencing of alcoholism: I've never experienced alcoholism. Is my best bet to try to experience it intellectually through books, workshops, and seminars? I think not! I have found that the best way I can approximate the vsceral experience, the despair, jubilation, madness, and agony is to be with people who relive their experince verbally - and with real feeling. Sure, the intellectual grasp is important, but how much more real and meaningful it becomes when vicariously experienced at the emotional level. It's the next "best" thing to having been there myself.

It helps my credibility, too, with those people who are inclined to say, "How can you help me? You've never been there." Willingness to vicariously share and to respect the validity of their experiences has helped earn me the title of "honorable alcoholic" from my AA firneds - a title I am proud to have.

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Free education: I have attended alcoholism schools at universities in Utah, Colorado, and Oklahoma and several others with National Council on Alcoholism groups, and have heard therapists espouse the application of transactional analysis, Gestalt therapy, behavior modification, reality therapy, rational emotive therapy, and other techniques. I swear to God, after that kind of exposure (which has certainly been good and worthwhile), I have learned more about alcoholism - its treatment and mistreatment, and the ways it affects people and families - at open meetings of AA and Al-Anon. And it's free! And it's in my own community, wherever I am.

Experience love and fellowship: To me, an ongoing relationship with AA is an ongoing exposure to love and warm fellowship. Now I guess I can grasp that intellectually and have it in mind when I refer someone to AA. But that sure ain't no substitute for walking in the door of the Saturday-night open meeting of the East Side Group in Panama City, Fla., and have Dot S., a loving Al-Anon, hug me and make me feel welcome. Or to have Curly D., and AA, take my hand in his burly paw and say, "Good to see you," and mean it. There's a feeling there that transcends learning. And I believe that if you don't know the feeling, you don't know the program.

Professional sustenance: Working with alcoholics in the depths of their illness is a discouraging business, and if all I ever saw were sick alcoholics, it would be devastating. (Note the dropout rate among professionals in the field.) By attending AA meetings, I can associate with well alcoholics, and that sustains me in dealing with the sick alcoholic. Hearing their stories, knowing how it was for them, enables me to see the potential for recovery in others. As I have often said, "Seeing you sober and envisioning your sickness enables me to see the sickness in the drinking alcoholic and envision his sobriety." That gives me strength.

Increased exposure: Many of the clients of our agencies are the poorly paid, the powerless, and the poorly educated. If those were the only alcoholics I saw, I'd get a distorted view of the cross section of humanity that is affected by this disease. By attending open AA meetings, I become exposed to the case histories of the business person, the society matron, the professional person, the top-level military officer, the rich as well as the poor, the highly educated as well as the illiterate, and I experience a more realistic sampling. If not for open AA meetings, I wouldn't have met the pilots, the

dentists, the clergymen, the lawyers, the working women, the housewives, who have experienced the devastation of alcoholism just as deeply as have our agency clients.

Source of material: As a public educator, I'm always on the alert for entertaining jokes and stories. At AA meetings, I have heard enough stories to fill a large book. Unfortunately I wasn't taking notes. However, I can remember enough material to include anecdotes and jokes in my presentations, to liven them up. Nearly all have been "borrowed" from AA speakers who were introducing some levity into their stories. Finding humor at AA meetings surprised me initially. Now, I find it an ongoing delight.

Twelfth Step referrals: A major benefit of being closely in contact with AA people is personally knowing the stories of well alcoholics. By knowing what it was like, what happened, and what it's like now with them, I can better decide whom to call when a client wants to talk with someone "who's been there." What a joy (and relief) it is to discover where my client is at and to say, "Would you like to talk to someone who's been where you are now and was able to do something about it?" - and to have a specific someone in mind. "Selective referral," I call it, and it beats the hell out of guesswork.

First-name friendships: Ongoing contact with AA brings me a degree of acceptance in the community of recovered alcoholics. I buy my gas from one AA member and have my dental work done by another, and I have numerous contacts with AAs and Al-Anons outside of meetings. We know eachother because of our common interest in attending meetings. We are on a first-name basis and do a great deal of cross referring. I receive much more than I give, but I sometimes have an opportunity to be helpful I may be asked to cite a source of help for a youngster who's into drugs, or offer budget counseling for the indebted, or provide the name of a good therapist for someone sober but troubled. Similarly, I get recommendations and guidance from my AA and Al-Anon friends.

Avoid stereotyping: I don't know about others, but I tend to generalize when I deal with large numbers. When I do that with people, that's stereotyping. When I stereotype, I lose sight of the dignity and individuality of the person I'm dealing with. By frequently attending AA and Al-Anon meetings, I am reminded of the many faces of alcoholism and the many ways it is experienced by alcoholics and their families. With that reminder, I am more able to be human with my client and to deal with the person, not the label.

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If ever I had the point driven home that there's no such thing as a "typical" alcoholic, it was in observing the milling throng of approximately 20,000 at the AA International Convention in Denver, in 1975. I saw men and women of every racial and ethnic group, of every occupational and economic classification, and of all ages. God, what a blessing to be exposed to that reality!

Uncover my real feelings: By attending AA meetings, I am able to get in touch with my real feelings about alcoholics. If, for example, I avoid AA and alcoholics because I'm afraid I might be considered one of them, am I not revealing my belief that alcoholism is a shameful condition? By refusing or avoiding contact with those who call themselves recovering alcoholics, am I not conveying my doubts about prospects for recovery? By avoiding alcoholics outside the treatment situation, am I not transmitting the message, "I'm okay, and you're not okay"? And what does that say about my attitudes?

I hasten to say it's no great sin to have such attitudes; they come with the society in which we live. But for heaven's sake, if I'm going to work with alcoholics and their families, I must recognize them and work on changing them. To work in the field and not do so breeds depression, discouragement, ulcers, resentments, and a short, unhappy career marked by little success. I must get in touch with all my negative feelings and deal with them, for my sake as well as my clients'.

Personal growth: Since I invest my time in attending open meetings of AA and Al-Anon, I may as well get something for myself. I have discovered there's a lot to be gained by trying to incorporate the Twelve Steps of those programs into my life. The soundness of the Steps is demonstrated by the growth of the Fellowship over the past forty-two years, and also by the adoption of the Steps by other self-help groups such as Gamblers Anonymous, Parents Anonymous, and Neurotics Anonymous.

I have discovered that by working the Twelve Steps in my life and by taking what I want from the meetings I attend, I grow personally as well as professionally. Also, I have been able to make contact with my spiritual self, something that had eluded me prior to my AA relationship.

Common bond: By bringing the Twelve Steps, the Serenity Prayer, and other AA tools into my life, I have reached a common ground with the recovering alcoholic. We don't have the commonality of the alcoholic experience, but we can have a common bond in working the Steps. If I allow myself to try to find a God of

of my own understanding, or to make a searching and fearless moral inventory, or to admit to God, to myself, and to another human being the exact nature of my wrongs, or to become ready to have God remove all my defects of character, am I not on common grounds with the recovering alcoholic? By bringing my experience closer to his, am I not sharing my humanity as well as my professional capabilities? And does that not contribute to the growth of both of us? I think so.

Source of ideas and speakers: In my job, I run group counseling sessions. I find AA open meetings to be a rich source of ideas, topics, and guest speakers for my groups and classes. By attending many meetings at many different groups, I get stimulating ideas from people who share their experiences as they carry the message.

My hope is that others in the field of alcoholism education or rehabilitation enjoy the same closeness to AA. It has helped me. I've always been made welcome. Attending has contributed to my knowledge and growth. I'm confident that if others in the professions caring for alcoholics allow themselves the experience, the same will happen. For those who don't, may I recommend the Serenity Prayer? It will help!

by Lee A. Grutchfield, M.Ed.

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PLAN OF INSTRUCTION/LESSON PLAN PART I

NAME OF INSTRUCTOR	COURSE TITLE
	Drug and Alcohol Abuse Control

BLOCK NUMBER	BLOCK TITLE
IV	Program Management and Application

1 COURSE CONTENT

4. Drug Rehabilitation Models

a. Identify and promote programs which offer alternative activities to drug abuse.

SUPPORT MATERIALS AND GUIDANCE

Audio-Visual Aids
35mm Slides, Drug Rehabilitation Models
16mm Film, "Narcotics File", (FLC 14-0111, 25 min)

Instructional Guidance
Describe the basic approaches to drug abuse rehabilitation. Emphasize the basic drug treatment/rehabilitation modalities and the application of the local Air Force drug rehabilitation programs. Discuss the rehabilitation programs offered in the civilian community: Therapeutic communities, methadone maintenance programs, and free clinics. Stress their significance for the referral of members who are being separated from the service and for the referral of civilians.

5. Review, Measurement and Critique

a. Review
b. Measurement
c. Critique

SUPERVISOR APPROVAL OF LESSON PLAN (PART II)

SIGNATURE AND DATE	SIGNATURE AND DATE

PART II - TEACHING GUIDE

INTRODUCTION (5 Minutes)

ATTENTION

"When one of our members falls victim to drug abuse, we are all diminished by the loss. When one of us is reclaimed from drug abuse, we are all enriched." (Quote of Dr Robert L. DuPont, Director of Special Actions Office of Drug Abuse Programs (SAODAP), Drug Abuse Prevention Report, Volume I, Number 5.)

MOTIVATION

Dr DuPont's remarks are quoted from a speech in which he outlined SAODAP's program objectives for 1974. He also stated, "Society has placed ex-addicts in double jeopardy. Too often, individuals are first damned for their drug-abusing behavior; then, once that has been controlled through treatment, they continue to be ostracized by society for their past sins. Treatment programs, themselves, have also failed. It is not enough just to get an addict into treatment. Treatment is not the end of the road. It is the beginning of a process of turning an individual around from a self-destructive existence to a productive, self-sufficient life."

OVERVIEW

1. Cover the lesson objectives with the class.

2. Develop the lesson chronology.

3. Today, we will examine several features of rehabilitation programs, including the Air Force rehabilitation efforts. Upon completion, you will be able to identify several commonalities of the majority of programs and better guide your clients into the most productive rehabilitation modality available to them.

TRANSITION

Let's begin by discussing some basic treatment/rehabilitation modalities applied to drug abuse rehabilitation.

BODY (1 Hour 45 Minutes)

PRESENTATION

3a. CRITERION OBJECTIVE: Identify a brief description of the three basic treatment/rehabilitation modalities applied to drug abuse rehabilitation.

1. Explain the basis for drug rehabilitation modalities.

a. Modality is synonymous with method.

b. The following is a statement from Grassroots, May 1974 Supplement, "Introduction to Treatment and Rehabilitation."

"Whether the issue is what causes addiction, the number of addicts,

the range of programs, or the reason for failure, one common thread is the multitude of facts and figures presented to explain each issue. Treatment, however, stands alone as the element which is quantitatively simple because there are only three basic treatment methods: Incarceration, Drug-Free, and Chemical."

2. Discuss incarceration as one form of drug treatment.

a. Incarceration may not mean actual imprisonment.

b. Involves restrictions of freedom, isolation of the incarcerated person, from the general society.

c. Confines the wrongdoer to protect society.

d. Provides the individual an opportunity to rehabilitate within the limits of structured society.

e. Federal incarceration units (clinical research centers) located at Fort Worth, Texas, and Lexington, Kentucky, were established in the mid-1930s, and stood as the only treatment available to addicts until 1958.

f. Incarceration has been highly unsuccessful.

g. A New York City Health Services Administration study reflects that ninety percent of patients released were re-addicted within one year.

h. State incarceration programs have met with similar lack of success.

3. Discuss the drug-free approach as the second basic modality of treatment.

a. Requires abstinence from chemical abuse or use.

b. Enforced abstinence allows addicts a chance to lead their lives without relying on drugs.

(1) Originally involved "cold-turkey" withdrawal.

(2) Chemical detoxification, followed by enforced abstinence, is currently more attractive.

c. Three distinct phases of drug-free modality.

(1) Detoxification on inpatient or outpatient basis, depending on program philosophy.

(a) Detoxification phase is generally a period of from seven to ten days.

(b) Followed by residential treatment and aftercare programs.

(2) Residential treatment is generally found as a "therapeutic-community" setting. (Explained later in this lesson.)

(3) Ambulatory or day-care treatment is "follow-on support," which includes:

(a) Counseling.

(b) Continuing interaction with "community activities" and people.

4. Discuss the chemical approach to drug treatment.

a. Two forms of the chemical approach to treatment are used in the United States.

(1) Chemical maintenance replaces illegitimate addiction with legitimate addiction.

(2) Narcotic antagonists blockade effects of heroin.

b. Methadone is the most common form of chemical maintenance.

(1) Methadone maintenance is treated separately later in this lesson.

(2) Heroin maintenance has been proposed, but is not presently in use in the United States.

5. Stress the fact that it is doubtful that anyone will see any one modality of treatment in its pure form, operating to the exclusion of other modalities. Examples include:

a. Prisons may apply incarceration in combination with drug-free modalities.

b. Therapeutic communities (drug-free approach) impose stringent restrictions on

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residents as a form of the incarceration approach.

PRESENTATION

7b. CRITERION OBJECTIVE: Identify five advantages and five disadvantages of methadone maintenance programs.

1. Explain the origin of methadone.

a. First synthesized in 1943, by the Germans; used as a painkiller.

b. First application to ease heroin withdrawal in 1948.

c. Studied by Dr Vincent P. Dole and Dr Marie Nyswander in 1963.

(1) Discovered that methadone would block heroin hunger.

(2) Studies conducted at Rockefeller University concluded that addiction could be treated similar to the treatment of diabetes.

(3) Heroin hunger was similar to the metabolic disorder requiring diabetic persons to need insulin.

(4) Use of methadone would correct the metabolic deficiency and end requirement for heroin, allowing the addict to live a relatively normal life.

(5) Methadone was proposed as a life-long maintenance program.

2. Discuss the five advantages of methadone maintenance over other forms of narcotics maintenance as described by Drs Dole and Nyswander.

a. Can be administered orally.

b. Has an extended duration of effectiveness (24-36 hours).

c. No serious side effects in maintenance doses.

d. At sufficient dose levels, methadone will block heroin effects.

e. Administered therapeutically, euphoria does not occur after tolerance has been established.

3. Identify the five disadvantages of methadone maintenance, according to Henry Lennard, et al (Grassroots reprint of a Smithsonian Magazine article).

a. Blockade theory is a myth. Blockage occurs only for small amounts of heroin. Euphoria is possible with large doses of heroin.

b. Method of administration, not the substance methadone, is beneficial. Oral administration of heroin would produce similar results. Injections of methadone produce euphoria.

c. Methadone does not produce cross-tolerance with non-opiate drugs; therefore, other drugs can be used for euphoria while taking methadone.

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(1) A study of forty methadone patients revealed that 82.5% had used at least one other drug (detected by urinalysis).

(2) Seventy-seven point four percent had used heroin concurrently with methadone.

d. Methadone patients tire more easily, are somnolent, and require more sleep than non-drugged individuals.

e. Reflexes of methadone patients are somewhat abnormal. They prespire profusely, are often constipated, and sexual impotence often occurs.

4. Stress that the differing opinions presented on methadone are those of proponents of methadone maintenance. The subject is highly controversial.

5. Urge students to research the subject and form their own opinions.

6. Federal law requires established period of addiction before personnel are allowed to enter a methadone maintenance program.

7. State that the Air Force does not use methadone maintenance programs. Air Force members are expected to be rehabilitated to the point that they can remain drug-free.

PRESENTATION

7c. CRITERION OBJECTIVE: Identify which treatment modality concept

is applied in each phase of the localized Air Force rehabilitation program.

1. Explain the treatment modality concept of Phase I.

a. Identification phase, cannot be construed as a treatment modality.

b. Identification of the client is common to all programs.

2. Explain that Phase II, detoxification, relates to two basic treatment modalities; drug-free and incarceration.

a. The drug-free modality is identified in Air Force Regulation (AFR) 30-2, paragraph 4-27a "Detoxification must be accomplished in a drug-free environment."

b. The Incarceration modality is implied in paragraph 4-27 of AFR 30-2: ". . .at the nearest medical facility. . . ." The individual's freedom would be restricted. He/she could not come and go as he/she desired.

3. Explain Phase III treatment modality concept.

a. Medical evaluation phase.

b. May include two basic treatment modalities.

(1) Incarceration may be applied if the client is admitted on an inpatient status.

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(2) The drug-free modality is also applied.

4. Discuss the Phase IV treatment modality concept.

a. Requires the drug-free application as administered in local rehabilitation programs

b. Will not normally involve incarceration.

5. Explain the Phase V treatment modality.

a. Uses drug-free madolity.

b. Enforced abstinance, while individual readjusts to his/her role without drugs.

PRESENTATION

7d. CRITERION OBJECTIVE: Identify the purpose of the free clinic.

1. Explain that the free clinic and therapeutic-community approaches to drug abuse rehabilitation should not be considered as primary treatment sources for active-duty Air Force personnel.

a. Identified drug abusers are automatically entered into the Air Force five-phase program.

b. These sources may be considered as referral agencies for those individuals who are not Air Force members who will be discharged from the Air Force.

2. Discuss the purpose of the free clinic.

a. The purpose of the free clinic is to provide free medical and dental care short of surgery.

b. Clinic personnel believe treatment is a right, not a privilege.

c. The free clinic movement began in Haight-Ashbury district, San Francisco, to treat the "hippie" life style, where funds were short, but the youth of the area required help.

d. The services offered by many of these free clinics indlude:

(1) Medical care.

(2) Dental care.

(3) Draft and individual counseling.

(4) Birth control and venereal disease treatment.

e. Free clinics do not serve the "bureaucracy." They serve the immediate needs of their clientele.

f. Base-level Social Actions offices should maintain close liaison with the local free clinic for information, guest speakers, drug trends, civilian drug treatment, etc.

PRESENTATION

7e. CRITERION OBJECTIVE: Identify the definition of a therapeutic community (long-term rehabilitation program) and its modality of rehabilitation.

Define the therapuetic-community concept.

a. Therapuetic communities are long-term treatment programs, generally operated under the drug-free modality, with members accepting (voluntarily) certain restrictions of their freedom. They usually have two basic rules:

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(1) No violence.

(2) No holding or use of chemicals.

b. The original therapeutic community was Synanon in Synanon, California, extablished in 1958.

c. Individuals who go to therapeutic communities generally stay for an extended period of time, experiencing withdrawal from the drugs they have been using, gaining rights and responsibilities in the community, and eventually venturing into "straight society" to hold a job and contribute to the support of the therapeutic community.

d. Several important factors contributing to the success of the therapeutic-community concept are:

(1) Admission is voluntary.

(2) Peers have experienced the drugs and games of the individual.

(3) Strict discipline is self-imposed and accepted.

APPLICATION/EVALUATION

1. What are the three primary treatment/rehabilitation modalities?

2. What are some advantages and disadvantages of the methadone maintenance programs?

3. Which treatment modality is

not used in Air Force rehabilitation programs?

4. What two types of rehabilitation efforts are generally inappropriate of Air Force members?

CONCLUSION (10 Minutes)

SUMMARY

1. The three basic treatment/rehabilitation modalities are:

a. Incarceration.

b. Drug-free

c. Chemical

2. Five advantages and five disadvantages of methadone maintenance programs are:

a. Advantages:

(1) Can be administered orally.

(2) Extended duration of effects.

(3) No serious side effects in maintenance doses.

(4) Blocks heroin effects.

(5) Administered therapeutically, euphoria does not occur after tolerance is established.

b. Disadvantages:

(1) No blockade of euphoria.

(2) Effect of methadone is caused by method of administration (oral).

(3) No cross-tolerance with non-opiate drugs; ineffective for poly-drug abuse.

(4) Side effects.

(5) Reflexes of methadone patients are abnormal; other side effects.

3. Treatment concepts applied in local rehabilitation.

4. Free clinics and therapeutic communities.

REMOTIVATION

The rehabilitation model applied to an individual must correspond to the ultimate destination of that particular unique individual, the client. In the Social Actions career field, you will encounter not only military personnel who will be rehabilitated through a military program, but must also be prepared to make referrals for civilians, Air Force dependents, and for military personnel who will be leaving the military. With the information available, you are prepared to accurately apply the particular rehabilitation models available to you and your clients. I urge you to maintain current information on available rehabilitation modalities.

CLOSURE

There is an abundance of literature available pertaining to

rehabilitation models. It is a controversial subject which may never be totally resolved. You are invited to attempt to understand the controversy, rather than become a specialist, advocating one singular concept of rehabilitation for all. Thank you for your attention.

ASSIGNMENT

Give complementary technical training assignment, when appropriate.

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STUDY GUIDE AND WORKBOOK

3ALR73430B/30LR7361B/30ZR7364B-IV-4-1

Technical Training

Drug and Alcohol Abuse Control

Program Management

DRUG REHABILITATION MODELS

1 August 1978

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SW 3ALR73430B
30LR7361B/30ZR7364B-IV-4-1
1 August 1978

Social Actions Training Branch
Lackland Air Force Base, Texas

Program Management

DRUG REHABILITATION MODELS

OBJECTIVE

Identify and promote programs which offer alternative activities to drug abuse.

INTRODUCTION

Getting a drug abuser into treatment in itself is not sufficient because treatment is not the cure of the disease. Treatment is the beginning of a process of turning the chemically dependent person around from a self-destructive existence to a productive, self-sufficient life. The information presented in this unit will acquaint you with the various treatment modalities so that you can make adequate referrals for those individuals who do not qualify for Air Force rehabilitation programs. It will also help you to be aware of other techniques that work with different types of people, and the tremendous resources that are available in your community.

INFORMATION

BASIC TREATMENT/REHABILITATION MODALITIES

A modality is synonymous (same as) with a method. Then treatment/rehabilitation modalities are methods of treatment/rehabilitation. Usually there are several modalities of rehabilitating people. Modalities have their own strengths and weaknesses, and are more suited for certain situations and people than for others.

The May 1974 supplement to Grassroots states, "Whether the issue is what causes addiction, the number of addicts, the range of problems, or the reason for failure, one common thread is the multitude of facts and figures presented to explain each issue. Treatment, however, stands alone as the element which is quantitatively simple because there are only three basic treatment methods: Incarceration, Drug Free, and Chemical."

First, we'll examine each of these three modalities, and then later we'll identify which modalities are used by various treatment programs.

INCARCERATION

Incarceration involves restriction of freedom-isolation of the incarcerated person from the general society. Incarceration may not mean actual imprisonment in all cases, but in some cases imprisonment does occur. In discussing incarceration, we'll look at its purpose, method and results.

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Purpose of Incarceration

The purpose of incarceration is to confine the wrong-doer to protect society. If the drug abuser is isolated from society, then there is less likelihood of that person influencing others to abuse drugs, and stealing to support a drug habit. Incarceration also provides certain opportunities for rehabilitation that are not available in the society at large.

Method of Rehabilitation

Incarceration provides the drug abuser an opportunity to rehabilitate him/herself within the limits of a very structured society. For example, the very structured prison society may provide the opportunity to resocialize persons who, if were free to do what they wished, would continue to abuse drugs. Regimentation is possible in incarceration, and new habits can be formed.

Results of Incarceration

Results of incarceration as a treatment/rehabilitation modality have been highly unsuccessful. The following studies indicate the lack of success with the incarceration method.

FEDERAL INCARCERATION UNITS. Federal Incarceration Units (Clinical Research Centers) located at Fort Worth, Texas, and Lexington, Kentucky were established in the mid-1930's, and stood as the only treatment available until 1958. A New York City Health Services Administration study reflects that 90 percent of patients released from either Lexington or Fort Worth were readdicted within one year of release.

STATE PROGRAMS. State incarceration programs have met with similar lack of success. Addicts who are released and returned to environments that produced their addiction without any supportive services usually return to addiction. In New York City, for example, the State Narcotic Addiction Control Commission (NACC) operates a series of large institutional programs. They report that only an estimated 19 percent of the NACC patients are "doing well" in aftercare.

DRUG-FREE

The next treatment/rehabilitation modality to be discussed is the drug-free approach. The drug-free approach required abstinence from chemical abuse, either voluntarily or enforced, although most are enforced at least upon entering the program.

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Purpose

The purpose of the drug-free modality is to allow the person to rid him/herself from the addictive properties of the drug sufficiently so that counseling and other treatment/rehabilitation methods can be used to help the person make clearer life decisions. The drug-free approach allows the addicts to examine their lives without relying on drugs.

Method

Abstinence is usually enforced. Originally, the drug-free approach often required "cold-turkey" withdrawal, in which no medication was administered and the person had to suffer the pain of withdrawal. Now chemical detoxification followed by enforced abstinance is currently more attractive.

PHASES. Three distinct phases of the drug-free modality exist: detoxification, residential treatment, and ambulatory or daycare treatment.

Detoxification. Detoxification is conducted on an inpatient or outpatient basis, depending on the program philosophy used. The detoxification phase is generally a period of seven to ten days which includes the complete withdrawal of the patient. The detoxification phase is generally followed by residential treatment and aftercare programs.

Residential Treatment. Residential treatment is generally a "therapeutic community" approach in which the patient generally participates in group and individual counseling while living among the group he/she counsels with. (Therapeutic communities are discussed in a later objective.)

Ambulatory or Daycare Treatment. This phase is follow-on support or aftercare which often includes counseling and interaction with community activities and people outside the therapeutic community. This phase helps the person bridge the gap between the "safe" therapeutic community and the relatively unstructured society at large.

CHEMICAL APPROACH

The chemical approach gives the patient another drug to either counteract or substitute for the drug on which the patient has become addicted. There are basically two types of chemical (narcotic) antagonists, and two types of maintenance programs.

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Chemical Maintenance

Chemical maintenance replaces the illegal, and often impure, drug with another drug secured under legitimate circumstances. There are basically two types of chemical maintenance: Methadone and heroin maintenance. Both methods seek to maintain the chemically dependent person on a drug that is legal so that the person can divorce him/herself from illegal lifestyles and develop a positive self-image.

METHADONE. Methadone maintenance is the most common form of chemical maintenance, and is the only legal narcotic maintenance program in the United States. Methadone has slightly different effects than heroin, but most importantly, it is legal at methadone clinics, and is more likely to be pure than street heroin. (See the next objective for a further explanation of methadone maintenance.)

HEROIN. Heroin maintenance, although not used in the United States, has been used in Great Britain and other countries. Once an addict positively identifies him/herself as physically dependent on heroin, he/she is eligible to receive controlled dosages of heroin. This prevents the patient from engaging in illegal life styles to support his/her drug habit.

Chemical (Narcotic) Antagonists

There are several types of chemical (narcotic) antagonists. Some are nonaddictive and cannot produce a "high" even if taken intravenously. The two most common are naloxone and cyclazocaine. Their duration is twenty-four hours or less. Because of their nonaddictive nature (non-pleasure-producing) it is extremely difficult to interest patients in appearing for their daily dosage. Methadone patients appear for their daily "fix" with methadone because it prevents methadone withdrawal. As of yet, no large scale method of using chemical antagonists has been found; however, scientists are searching.

EXERCISE 7a

Complete the following questions.

1. Name the three major treatment/rehabilitation modalities.

2. What is the purpose of incarceration?

3. What are the three phases of the drug-free approach?

4. Which form of the chemical approach is used in the United States?

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METHADONE MAINTENANCE

Methadone maintenance is a very controversial subject. Therefore our approach with this section is to point out some of the differing views regarding this form of treatment. You will need to do further research on your own in order to decide for yourself the usefulness of methadone maintenance and its applicability to your civilian military dependent clients. We'll first look at the origin and some basic information about methadone, then examine the pros and cons of methadone maintenance.

ORIGIN

Synthesis

Methadone was first synthesized in 1943 by the Germans. They used methadone as a pain-killer to substitute for morphine, which was difficult to obtain during the war years.

Use to Aid Heroin Withdrawal

Methadone was first used to ease the pain of heroin withdrawal in 1948. It can be used in this manner because of its cross tolerance with heroin.

Methadone Maintenance

The use of methadone as part of a maintenance program for heroin addicts in this country came about largely through the research of Dr. Vincent P. Dole and Dr. Marie Nyswander in 1963. They studied thirty-four hundred patients in New York. Many methadone maintenance programs are modeled after their program. Drs. Dole and Nyswander found the following things from their research:

BLOCKAGE OF HEROIN. Dole and Nyswander discovered that methadone, at certain dose levels (80-120 mgs) would block heroin.

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ADDICTION SIMILAR TO DIABETES. Studies conducted at Rockefeller University concluded that addiction could be treated similar to treatment of diabetes by giving addicts a daily dose of methadone.

COMPARISON WITH INSULIN. Heroin hunger was similar to the metabolic disorder requiring diabetic persons to need insulin. As diabetics could be maintained on insulin, so heroin addicts could be maintained on methadone.

USE OF METHADONE. Methadone, it was theorized, would correct the metabolic deficiency and end the requirement for heroin, allowing the addict to live a relatively normal life.

LIFE-LONG MAINTENANCE. Methadone was proposed as a life-long maintenance program. Dole and Nyswander thought that addicts would have to be maintained for life on methadone. There may be a few addicts who will be able to abandon drugs entirely, but such abstinence was not expected, and was not the goal of the Dole and Nyswander methadone maintenance programs.

ADVANTAGES

The following are advantages reported by Dole and Nyswander. In comparing these advantages with the disadvantages as seen by Henry Lennard, et al, you will notice some disagreement about the facts. This disagreement and the resultant controversy is why we give both views. First, let's look at the possible advantages.

Oral Administration

Methadone can be administered orally and thus is less cumbersome and less costly than heroin.

Longer Duration

Methadone has an extended duration of effectiveness (24-36 hours). This of course, is longer than heroin which only lasts six to eight hours.

No Side Effects

There are no serious effects from methadone in maintenance doses.

Block Heroin Effects

At sufficient dose levels, methadone will block heroin effects.

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No Euphoria

Administered therapeutically, euphoria does not occur after tolerance has been established.

DISADVANTAGES

The disadvantages presented here are taken from an article by Henry Lennard, et. al., "The Cure Becomes a Problem," reprinted by Grassroots in 1974 from Smithsonian Magazine.

Blockade Theory a Myth

The blockade theory presented by Dole and Nyswander is a myth. Blockade of heroin effects occurs only for small amounts of heroin. Euphoria is possible with large doses of heroin.

The Method of Administration Makes the Difference

The method of administration, not the substance, methadone, is beneficial. Oral administration of heroin would produce similar results. Injections of methadone produce euphoria.

Cross-tolerance with Only Opiate Drugs

Methadone does not produce cross-tolerance with non-opiate drugs; therefore, other drugs can be used for euphoria while taking methadone.

HEROIN USE WITH METHADONE. Seventy-seven percent had used heroin concurrently with methadone.

USE OF OTHER DRUGS WITH METHADONE. Carl Chambers of the New York State Narcotic Addiction Control Commission and Russel Taylor of Philadelphia General Hospital studied forty patients on methadone maintenance. They found that 82.5 per cent of the patients had used at least one other drug while on methadone maintenance. The use of other drugs was documented by urinalysis results. Thirty per cent had used barbiturates, and twenty-five per cent had used amphetamines concurrently with methadone.

Fatigue

Methadone patients tire more easily, are somnolent (tend to fall asleep), and require more sleep than non-drugged people.

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Abnormal Reflexes

Reflexes of methadone patients are somewhat abnormal. They perspire profusely, are often constipated, and are often sexually impotent, especially older men.

REGULATIONS

Federal Laws

Because of the potential of abusing methadone, federal law requires an established period of addiction before a person is allowed to enter a methadone maintenance program.

Air Force Does Not Use Methadone Maintenance

Because Air Force members are expected to be rehabilitated to the point that they can remain drug-free, and because the Air Force is not in the long-term rehabilitation business, the Air Force does not use methadone maintenance programs as a method of rehabilitation. However, it is possible for you to refer a DAF civilian or dependent who has had long-term problems with heroin addiction to civilian or government methadone maintenance programs.

EXERCISE 7b

Complete the following exercise.

1. How did methadone become a maintenance program for heroin addicts?

2. What are the five advantages of methadone maintenance according to Dole and Nyswander?

3. What are the five disadvantages of methadone maintenance according to Henry Lennard?

4. How does the Air Force view the use of methadone maintenance for its members?

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TREATMENT MODALITY CONCEPTS IN AIR FORCE REHABILITATION

The five-phased Air Force Drug Rehabilitation Program contains certain similarities with the three basic treatment modalities discussed in the first section of this study guide and workbook. Let us now examine the Air Force Rehabilitation Program from this perspective so that we can thoroughly understand both the Air Force Rehabilitation Program and the three basic treatment modalities.

PHASE I, IDENTIFICATION

Identification Not Treatment Modality

Identification cannot be construed as a treatment modality; therefore, the modality comparisons are not applicable to this phase.

Commonality

Identification, however, is something all rehabilitation programs have in common. Each rehabilitation program must in some way identify the clients be it voluntary, mandatory referral, medical referral, or law enforcement referral.

PHASE II, DETOXIFICATION

Phase II, detoxification contains two treatment modalities: drug-free and incarceration.

Drug-Free

The drug-free modality is identified in Air Force Regulation 30-2 in the following quote, "Detoxification must be accomplished in a drug-free environment."

Incarceration

The incarceration modality is implied by the statement that detoxification will be accomplished "...at the nearest medical facility..." To accomplish detoxification with assurity it is necessary to restrict

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the rehabilitee's freedom so that the facility can insure that the person remains drug-free long enough to withdraw the effects of the drug.

PHASE III, MEDICAL EVALUATION AND TREATMENT

Phase III is mandatory for all substantiated drug abusers, and medical treatment is provided as indicated. The purpose of this phase is to determine the appropriate medical treatment and disposition of each individual. Two basic treatment modalities may be used during this phase: Incarceration and drug-free.

Incarceration

Incarceration may be applied if the client is admitted on an in-patient status for evaluation. This is more likely if the client is drug-dependent, or has related medical/psychiatric problems. In these cases, the client is likely to have his/her freedom restricted.

Drug-Free

The drug-free modality is also applied, as the client is expected to remain drug-free during this phase.

PHASE IV, BEHAVIORAL REORIENTATION

The objective of Phase IV is to redirect the behavior of individual rehabilitees so that they voluntarily conform to Air Force standards of performance and conduct. During Phase IV, normally the drug-free modality is the only one used.

Drug-Free

Phase IV regimens require the client to remain drug-free, and this is verified through regular urinalysis testing. The drug-free method allows the client to examine his/her life without being clouded by the effects of drugs. Phase IV also allows the client to test him/herself being without drugs while under the close supervision of a counselor who can help the client deal with emotional issues that often arise once the mask of drugs is lifted.

Restrictions

Although Phase IV participants normally have some restrictions, for the most part they do not involve any kind of confinement. These restrictions may be in jobs they can perform, their administrative situation, and in the fact they must report for counseling sessions and urinalysis. Phase IV clients are not generally isolated from the general society, and therefore, the incarceration modality is not said to be used in Phase IV.

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PHASE V, FOLLOW ON SUPPORT

Phase V is the process by which successful rehabilitees return to normal duty. There is only one treatment/rehabilitation modality applied during Phase V: Drug-Free.

Drug-Free

Members in Phase V are expected to remain drug-free. Their abstinence is tested by less frequent urinalysis than in Phase IV. Remaining drug-free while the client returns to the stresses of every day life without the crutch of drugs is critical to successful rehabilitation. Phase V is the real test of rehabilitation/success.

EXERCISE 7c

Complete the following exercise.

1. Why is there no treatment modality applied in Phase I?

2. How is incarceration involved in Phase II?

3. What modality(ies) is/are applied in Phase III?

4. Is incarceration a modality used in Phase IV? Explain.

5. Why is it so important to have enforced abstinence in Phase V?

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FREE CLINICS

One of the best referral agencies available for dependents and DAF civilians with drug or other personal problems is the free clinic. Most major cities in the United States have free clinics. Free clinics have established good rapport with their clientele primarily because they were established purely for the benefit of the people they serve. One of the most important aspects of free clinics is that the people who operate them are dedicated individuals whose chief motivation is to provide assistance to other people. Although free clinics should not be considered a primary treatment program for active duty military personnel, free clinics are very applicable to DAF civilians, Air National Guard, Reserve personnel, those being discharged, and dependents. They are excellent resources for guest speakers and current information. We'll examine the origin, purpose, and services of special interest to base social actions programs.

ORIGIN

The free clinic movement began in the Haight-Ashbury district of San Francisco, to treat people who had chosen the "hippie" life style. As the movement began funds were short, so professional and lay people volunteered their unique talents to help the youth of the area. As the years passed, the movement grew and broadened its base. Clients came from all walks of life, but particularly those who were underprivileged or who chose to seek assistance from people who cared and were not a part of the "establishment".

PURPOSE

Philosophy

Free clinic people believe that treatment is a right, not a privilege. Regardless of the client's economic, social, or philosophical orientation, that person has the right to medical care. Free clinic people believe in volunteering their help to insure all people are given this right. Free clinics do not serve the "bureaucracy." They serve the immediate needs of their clientele.

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Purpose

The purpose of the free clinic is to provide free medical and dental care short of sugery.

Services Offered

Free clinics offer a variety of services, depending on the skills of local volunteers. Most free clinics offer the following: Medical and dental care, group and individual counseling, birth control, and veneral disease treatment. In larger cities, other services may be offered from drug, unwanted pregnancy, women's rights, rape counseling to free universities and self-awareness training.

SERVICES OF SPECIAL INTEREST TO BASE SOCIAL ACTIONS

Base-level social actions offices should maintain close liaison with the local free clinic for the following reasons: The free clinic may provide a referral resource for Air National Guard Reserve, DAF civilians, and dependent drug rehabilitation. You may also want to refer personnel being discharged for drug abuse; or related reasons, to the free clinic. Free clinic personnel are often aware of drug trends and currently harmful drugs abused in the local area. Guest speakers may be found at the free clinic, who after screening, may make excellent additions to base level drug/alcohol education and commander's calls. The free clinic is often a center for volunteers interested in learning about and helping solve social problems. Often their training programs are applicable to social actions staff members.

EXERCISE 7d

Complete the following exercise.

1. Why are free clinics not sources of treatment for Air Force active duty personnel?

2. What is the purpose of the free clinic?

3. How can the free clinic be beneficial to social actions?

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THERAPEUTIC COMMUNITIES

One of the most successful treatment modalities for severely addicted people is the therapeutic community. No doubt the reason for their success is that their approach allows rehabilitees to determine, at least to some degree, their own rehabilitation goals. While civilian therapeutic communities are not applicable to active duty Air Force members who are entered in local base rehabilitation programs, therapeutic communities can be very useful for DAF civilian employees, dependents, Air National Guard, Reserve, and personnel being discharged because of drug or drug-related problems. We'll examine the definition of a therapeutic community, its origin, Synanon as an example, and the treatment modality of the therapeutic community.

INFORMATION

DEFINITION

Therapeutic communities are long-term treatment programs, generally operating under the drug-free modality, with members accepting (voluntarily) certain restrictions of their freedoms. Therapeutic communities usually have two basic rules:

No Violence

Violence is not tolerated among the community members, regardless of the situation.

Abstinence

No holding or use of chemicals is the second rule of the therapeutic community. Violators are required to terminate their stay at the community.

ORIGIN

The original therapeutic community for drug addiction treatment was Synanon, located in Santa Monica, California. It was established in 1958. Synanon was founded by Chuck Dederich who was a recovered alcoholic. Chuck

was a powerful, impressive speaker, and very persuasive in keeping people in the group. The Synanon, originally meant seminar. The founders believed that the basic message of Alcoholics Anonymous could be applied to drug addicts. Some of the AA members did not fit in with the drug abusers. Particularly in "hard drug" abusers there were some differences from alcoholics. For most drug abusers, drug abuse was their only way of life. They had not held a job, and could not get one readily, even if they abstained from drugs. The alcoholic, however, usually had held a job, and when sober could easily get a job. This difference shows why the therapeutic community, in which jobs for the newly detoxified addict were provided, worked so well. Starting with a handful of people, struggling through many trials, Synanon has grown to over nine hundred members today. They now have facilities in New York, Detroit, San Diego, Los Angeles, and San Francisco, in addition to their Santa Monica facility.

MODALITY OF THERAPEUTIC COMMUNITIES

Individuals who participate in a therapeutic community generally stay for an extended period of time. They experience withdrawal from the drugs they have been using, gain rights and responsibilities in the community, and eventually return to "straight society" to hold a job and contribute to the support of the therapeutic community. The chief therapeutic tool employed in the rehabilitation process is the encounter group, a form of aggressive and provocative interchange focusing upon the daily behavior of each group member. The therapeutic community operates under the drug-free modality, with members accepting certain restrictions of their freedom.

There are several treatment practices which contribute to the success of therapeutic communities:

Voluntary Admissions

Admission to therapeutic communities is voluntary. This is a definite motivation factor, but in and of itself is not sufficient for success. Many "fakers" who voluntarily come to live in the therapeutic community must be confronted by the group on whether they really want to give up drugs. These "fakers" may have joined the community to escape the law or other things.

Peer Influence

Peers have experienced drugs and games addicts play. It is difficult to "con" them, particularly in the community where new member's behavior is observed 24 hours a day. Peers confront misbehavior. Peers will not accept the addict until his/her behavior meets the community's standards. Peer pressure can be a very powerful force.

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Discipline

Strict discipline is self-imposed by the community members, and accepted by all members. For those who trangress "the haircut", a verbal reprimand for irresponsible behavior, may be used. Other actions to enforce discipline include "the probe", a five to ten hour session on a theme such as prejudice, or "the marathon", an extended encounter which also includes the expression of basic human emotions such as fear, anger, love, and pain, while getting down to the basic gut level. The discipline serves to provide structure for the drug abuser, who, for the most part, had little structure in his/her life. This type of "tough love" also serves to show the caring Synanon members have for each other.

EXERCISE 7e

Complete the following exercise.

1. Define the term therapeutic community as it applies to drug abuse treatment.

2. What are the two basic rules of a therapeutic community?

3. What factors contribute to the success of therapeutic communities?

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SUMMARY

In this unit we have discussed three modalities of treatment: Incarceration, Drug-free, and Chemical approach. We also looked at the advantages and disadvantages of methadone maintenance, as well as the treatment concepts applied in each of the five phases of the Air Force Drug Rehabilitation Program. Last, we discussed the applicability of the free clinics and therapeutic communities. Remember that the rehabilitation model applied to an individual must correspond to the ultimate destination of that particular unique individual, the client. In the social actions career field, you must be prepared to counsel not only military personnal who will be rehabilitated through a military program, but you must also be prepared to make referrals for civilians, Air Force dependents, Air National Guard Reserve and military personnel who will be discharged. With the information presented in this unit, you will be prepared to accurately apply the particular rehabilitation models available to you and your clients. You will also want to maintain current information on available rehabilitation modalities in the future.

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REFERENCES

1. AFR 30-2, Social Actions Program, 8 Nov 76

2. Lennard, Henry L., Epstein, Leon J., and Rosenthal, Mitchell S. "The Cure Becomes A New Problem," Smithsonian Magazine, April 1973. Reprinted Grassroots, June 1974.

3. Endure, Guy Synanon Garden City: Doubleday 1967, 1968.

4. DuPont, Robert L. Drug Abuse Prevention Report, Vol. 1, No. 5 1974.

5. "Introduction to Treatment and Rehabilitation," Grassroots May 1974.

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ANSWERS TO EXERCISES

EXERCISE 7a

1. Incarceration, drug-free and chemical
2. Protect society from the "wrong-doer".
3. Detoxification, residential treatment and ambulatory.
4. Narcotic antagonists and methadone maintenance.

EXERCISE 7b

1. Through the research of Dole and Nyswander, who found that heroin addicts could be maintained on methadone in much the same fashion as diabetics.
2. Oral administration; duration of effects; no serious side effects; blocks heroin effects; and there is no euphoria after established tolerance.
3. Blockade theory is a myth; method of administration not methadone is important; methadone does not have cross-tolerance with other drugs; methadone patients tire easily; and reflexes are somewhat abnormal.
4. The Air Force does not use methadone.

EXERCISE 7c

1. Phase one is identification and cannot be construed as a treatment modality.
2. Individual will be hospitalized with certain restrictions on freedom.
3. Incarceration and drug-free.
4. No, although members do have certain restrictions applied to them.
5. To give the individual ample opportunity to readjust to his/her role without drugs.

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EXERCISE 7d

1. Identified drug abusers are automatically entered into the Air Force five-phase rehabilitation program.

2. To provide free medical and dental care short of surgery.

3. They can provide information and guest speakers, advise of drug trends and civilian drug treatment.

EXERCISE 7e

1. Long-term treatment program, drug-free modality with certain restrictions.

2. No violence; no use of drugs.

3. Admission is voluntary; peers have experienced drugs and games; and discipline is self-imposed.

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PLAN OF INSTRUCTION/LESSON PLAN PART I

NAME OF INSTRUCTOR	COURSE TITLE
	Drug and Alcohol Abuse Control

BLOCK NUMBER	BLOCK TITLE
V	Principles and Techniques of Drug/Alcohol Education

1 **COURSE CONTENT**

1. Lecture Method

a. Given an evaluator-approved topic related to drugs/alcohol, satisfactorily prepare a fifteen-minute lecture-method lesson plan in accordance with the criteria listed on the Lecture Method Performance Test.

b. Identify recommended procedures for selection, preparation, and utilization of audio-visual aids and equipment to support drug/alcohol abuse control education programs.

c. Given an evaluator-approved 15-minute lecture lesson plan on a drug/alcohol-related subject, satisfactorily prepare appropriate support materials for the lesson in accordance with the Lecture Method Performance Test.

d. Given an evaluator-approved topic related to drugs/alcohol, satisfactorily present a 15-minute lecture in accordance with the criteria listed on the Lecture Method Performance Test.

SUPERVISOR APPROVAL OF LESSON PLAN (PART II)

SIGNATURE AND DATE	SIGNATURE AND DATE

PLAN OF INSTRUCTION NUMBER		DATE	PAGE NO.
L3ALR73430B/L30LR7361B/L30ZR7364B	1021	30 May 1978	45

ATC FORM OCT 75 133 PREVIOUS EDITION IS OBSOLETE

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SUPPORT MATERIALS AND GUIDANCE

Student Instructional Materials
HO B-V-1-2, Lecture-Method Practicum
SW B-V-1-1, Principles and Techniques of Drug/Alcohol Education

Audio-Visual Aids
35mm Slides, Assorted
16mm Films, Assorted
Transparencies, Assorted
Flip Chart, Principles and Techniques of Instruction - Introduction
Video Tape, Lecture Presentation
Video Tape (Blank)
CCTV

Training Methods
Lecture
Discussion/Performance

Instructional Guidance
Emphasize proper instructor characteristics and lecture-method teaching techinques. Discuss the strengths and weaknesses of the lecture method of instruction. Introduce the lesson plan and stress its purpose and importance. Discuss lesson plan organization and preparation. Have students watch and rate a student lecture presentation (video tape) and write the lesson plan for the presentation as practice. Cover the overall objectives of USAF drug and alcohol education programs. Stress successful and unsuccessful approaches to drug education. Discuss the significance of the A.D. Little and General Accounting Office studies of USAF substance abuse education. Emphasize study recommendations. Discuss the importance of audio-visual in support of classroom presentations. Demonstrate the use of the 35mm slide and overhead projectors in groups. Students receive the assignment of selecting a topic, writing a lesson plan, preparing support materials, and present a 15-minute lecture in the Introduction to Block II presentation. How to accomplish these tasks is explained to the students in the Lecture Method lectures. Insure that each student has an approved topic and is aware of the date and time for lesson-plan review and presentation. Review each student lesson plan prior to presentation. Review each student lesson plan prior to presentation and make recommendations for improvement. Arrange audio-visual equipment to be used. Each instructor is responsible for equipment used. Use CCTV system to enhance feedback on an availability basis. The lecture presentation performance exercise (practice session) is held on approximately days 14-17 and the performance tests will occur on days 23-25, thus, allowing students to research another topic and learn from their mistakes on the practice session.

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HANDOUT

3ALR73430B/30LR7361B/30ZR7364B-V-1-1

Technical Training

Drug and Alcohol Abuse Control

Principles and Techniques of Drug/Alcohol Education

LECTURE METHOD (PRACTICUM)

15 June 1978

HEADQUARTERS 3250 TECHNICAL TRAINING WING (ATC)
(USAF Technical Training School)
Lackland Air Force Base, Texas 78236

DESIGNED FOR ATC COURSE USE. DO NOT USE ON THE JOB.

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ATC FORM 214 (JAN 78) OBSOLETES ATC FORMS 214, MAY 68, 522, NOV 63 AND 523, MAY 71. STANDARD COVERSHEET

1600

Social Action Training Branch
Lackland Air Force Base, Texas

HO 3ALR73430B/30LR7361B/
30ZR7364B-II-V-1-1
31 May 1978

Principles and Techniques of Drug/Alcohol Education
LECTURE METHOD (PRACTICUM)

OBJECTIVES

By the conclusion of the Lecture Method Practicum in Block III, you should have received practice and feedback on formal lecture techniques; become familiar with what resources are available in the drug/alcohol field and how to use these resources to prepare educational presentations; gained knowledge and confidence in the areas you researched for your lectures; and shared and received the knowledge from the presentations on a variety of drug/alcohol-related topics.

The specific criterion objective is to prepare and present a fifteen minute lecture method lesson plan in accordance with the criteria listed on the lecture method Performance Test (See attachment 1).

INTRODUCTION

As a drug/alcohol abuse control specialist, nearly one-third of your time will be used in preparing and presenting drug/alcohol educational presentations. One of the most versatile methods of presenting educational material is the lecture technique. You will use lectures to present segments of the standardized educational packages, presentations at commanders calls, to wives clubs, to train volunteer helpers, to brief commanders, etc. The list of the application of the lecture technique goes on and on for the drug/alcohol specialist. In order to do your job, you must communicate, and in order to communicate effectively, you must organize your thoughts and present them in a lecture format. The Lecture Method Practicum gives you the opportunity to gain practice and feedback in this most useful skill. No matter how good a speaker you already are, this practicum gives you a chance to grow and become more effective. Listed below are some of the guidelines we use in the Lecture Method Practicum in order to help you receive maximum learning of this skill.

INFORMATION

GUIDELINES

The following guidelines are designed to help you understand what is required of you in the Lecture Method Practicum, as well as what areas of creativity we encourage.

Lecture and Lesson Plans

During the course each student will prepare two lesson plans to be used in presenting two fifteen-minute lectures on drug/alcohol subjects. The first lesson plan and lecture is for practice, while the second (fifteen-minute) lecture lesson plan is evaluated according

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Supersedes HO B-II-11-18, 8 August 1977.

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to the Lecture Method Performance Test (Attachment 1).

Topic Selection

You may choose your own lecture topic so long as it meets the following criteria:

DRUG/ALCOHOL RELATED. The topic must be drug/alcohol related. By related we mean that it must be useful to drug/alcohol abuse control specialist. Topics can include methods of counseling drug/alcohol abusers, pharmacology, crisis intervention, methods of rehabilitation, just to name a few related areas. We encourage you to use your creativity to select a topic. The relationship to the drug/alcohol field, however, must be readily apparent.

DEFINED AND LIMITED. The topic must be appropriately defined and limited so that you can adequately cover it in fifteen minutes. Do not use an "oversized" topic. Decide what you can say in the time allotted and limit your topic to that information.

REFERENCED. The topic must be referented in the Social Actions Training Branch, Human Resource, or Wilford Hall Medical Center libraries. You must provide the reference to your grading instructor upon request for verification of content and possible reworking of lesson plans. The purpose of writing this new lesson plan is to read and research something you have not read before so that this learning experience will be a challenge.

NOT AFR 30-2. Air Force Regulation 30-2 should not be the primary reference for any lecture presentation presented at the school. You will receive sufficient practice presenting Air Force regulations in the Guided Discussion Method Practicum when you present parts of the Air Force Standardized Education Packages.

NO DUPLICATES. The topic nor the content should be a duplicate of another student's lesson plan. You should not duplicate a previous subject area that you have presented before.

VARIETY OF TOPIC AREAS. Select your two topics from a variety of subject areas. For instance, if you talk about alcohol one time, drugs or counseling should be your next topic. The purpose in having a variety of topics is to encourage broadening of your field of expertise.

CREATIVITY ENCOURAGED. We encourage creative topics which relate one field of knowledge to another in a new way. When you read two books or articles and relate them, you often can come up with a new and exciting idea. This will stimulate your thinking, and the thinking of those who listen to your presentation.

Preparation

LECTURE TOPIC APPROVAL. Write your proposed topic on the list provided by the appointed time. The grading instructor will initial the topic if it is satisfactory. In some cases, however, you will need to limit or change your topic so as not to duplicate another student's lesson. If the topic is not initialed, see your grading instructor to negotiate a suitable topic.

LESSON PLAN EVALUATION. Turn your lesson plan in to your grading instructor at the appointed time for evaluation. Late lesson plans will constitute a practicum failure unless previously excused. Insure you follow the proper format. A sample of the prescribed format is contained in this handout. This error of failing to follow the correct format is often the cause of having to reaccomplish lesson plans. The format prescribed is the same format used in the Air Force Standardized education packages.

LESSON PLAN CORRECTION AND DUPLICATION. Once your lesson plan has been graded you should then add the corrections suggested to improve the plan before the day you are to present the lecture. These suggestions are designed to help you do a better job of presenting the lecture. If there were enough errors/problems with your lesson plan to require a remake, you normally will be given 24 hours to turn in a corrected copy. Once you have your corrected (final) copy, you must duplicate an additional copy for your instructor to use during grading. The Branch xerox machines are not authorized for this purpose. Suggest you use the xerox machines at the base library, or type the lesson plan and carbon copy with typewriters available for use from your instructor.

REQUEST AUDIO-VISUAL EQUIPMENT IN ADVANCE. When you turn in your lesson plan, let your grading instructor know what kind of visual aids you plan to use and whether you will need audio-visual equipment. There are numerous slides available from the library which may assist your presentation. You may choose to make overhead transparencies, or you may use flip charts or the chalkboard. Your grading instructor will assist you in finding the aids and supplies you need to get your message across. Be sure to notify your grading instructor in enough time for him/her to request the audio-visual equipment from supply.

PRESENT THE LECTURE. It is your responsibility to present your lecture at the appointed time. Failure to do this is considered an unsatisfactory practicum performance, unless previously excused. Practice dry-run your lecture with other students before the appointed time so that you are prepared. Use the attached grading criteria as that is what you will be graded on. If you deliver your presentation by these criteria you will do an outstanding job.

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Feedback

Your grading instructor will use the grading criteria and progress checklist to evaluate your presentation and give you feedback. Additionally, the videotape will be used to give feedback when it is available. You will find this a unique experience to gain maximum feedback. The purpose of feedback is to help you grow and improve your presentations. Please take feedback in this light and use it to gain other persons perception of your behavior.

Remakes

Occasionally, students need more practice in presenting lectures in order to present them at an acceptable level. In the case where one fails to meet the minimum standards, or in the case where you would like more practice even though you passed, your grading instructor will provide individualized assistance to help you improve your presentation. When remakes are required you will be given three days to prepare a <u>new</u> lesson plan. You may choose a new topic and prepare the lesson plan, or may choose from three already drafted by the school. The same criteria apply to remakes as the first presentation, and normally, a new instructor will be assigned to grade your remake.

Benefits

The Lecture Method Practicum is a unique opportunity for you to improve your lecture skills. We have many resources readily available here at the Social Actions Training Branch which you may continue to use once you are graduated. Take advantage of them while you are here.

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1604

SAMPLE LESSON PLANS

Fifteen-Minute Presentation

NAME _____ DATE _____

RANK _____ PRACTICE ____ EVALUATION ____ GROUP _____

REFERENCES: Are You Listening, Ralf G. Nichols and Leonard A. Stevens

The Art of Listening, Jud Morris

OBJECTIVES (Only the underlined portion is required)

1. Given information on bad habits of listening, identify ten bad habits of listening to the 100% level of proficiency.

2. Given information regarding methods to improve listening effectiveness, identify three methods to improve listening effectiveness at the 100% level of proficiency.

INTRODUCTION
(1 Minute)

ATTENTION

At the Police Academy, two members of the same family took first and second place in the target shoot contest. They then engaged in a "run-off" match to determine which was the best shot at the academy. The records indicated that the older one was the younger one's father. The younger one was not the older one's son. What was the relationship? Chances are you are thinking about solutions right now, and you are not listening completely to what I'm saying.

OVERVIEW

Today we will look at ten bad listening habits, sometimes known as the ten non-building blocks to effective listening. They are evaluation, non-critical inference, plural inference, attitude, lack of attention, wishful thinking, semantics, excessive talking, fear, and lack of humility. We will also consider three methods of improvement, the lone wolf, the buddy system, and the group approach methods.

MOTIVATION

With this information, you can bring to light your bad listening habits, and strive to work on them. Improving your listening will improve communication and help you enormously in single and group counseling.

TRANSITION

Let's now look at the ten non-building blocks of effective listening.

Attachment 1

1605

BODY (13 Minutes)

PRESENTATION	
1. Identify ten bad habits of listening.	Transparency # 1
a. Evaluation, judgment	Example: "Women are better off barefoot and pregnant."
(1) Evaluating things heard.	
(2) Decide whether correct/incorrect.	
(3) Formulate own opinions.	
(4) Listening ceases.	
b. Non-critical inference.	Transparency # 2
(1) Jumping to conclusions.	Reference the attention step.
(2) Supplying own information.	
c. Plural inference.	Transparency # 3
(1) Others think as we do.	"Everyone knows that."
d. Attitude	Transparency # 4
(1) Closed mind.	Stubborn
(2) Know the answer-won't listen if beliefs are contrary.	
e. Lack of attention	Transparency # 5
(1) Off and on listening	
(2) Attention span decreases as interest decreases.	Reference self
f. Wishful thinking (hearing)	Transparency # 6
(1) Hearing what you want to hear	Similar to Hitler and the Germans
(2) Not hearing what you don't want to hear.	
g. Excessive talking.	Transparency # 7
(1) Talking so much you can't get a word in.	

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h. Semantics - words, phrases mean different things to different people.	Transparency # 8 CB language etc.
i. Fear	Transparency # 9
(1) Inherently afraid of change.	Safe in beliefs - security.
(2) Hear things that conform to beliefs.	
j. Lack of humility.	Transparency # 10
(1) Being programed to think.	
(2) Listener inferior to talker.	Parent to child - listener must be the learner.
(3) Afraid to listen.	
	INTERIM SUMMARY TRANSITION Now that we have looked at bad listening habits, let's look at effective listening.
2. Identify three methods to improve listening.	Transparency # 11
a. Lone wolf method.	
(1) Know and understand the ten bad listening habits.	
(2) Make a chart and look at it often.	Draw example of chart on board.
b. Buddy system.	Draw example of chart on board
(1) Get moral support.	
(2) External conscience	
(3) Two heads better than one.	
(4) Get honest feedback.	
(5) Both people are teachers.	There is no better way to learn than to teach.
c. Group approach	
(1) If two are better than one, five are better than two.	Broader views - more input.

1607

(2) Develop listening in a group where listening is needed by you.

(a) Group counseling.

(b) Family — Give personal experiences.

(3) Side effects.

(a) Increased cooperation.

(b) Better team work. — Be sure to relate examples

(c) More effective communication.

EVALUATION

What are the ten bad habits of listening?

Answer: Evaluation, non-critical inference, plural inference, attitude, lack of attention, wishful thinking, excessive talking, semantics, fear, and lack of humility.

What are the three methods of improvement for effective listening?

Answer: Lone wolf, Buddy system, and Group approach.

CONCLUSION (1 Minute)

SUMMARY

We have taken a look at three methods of improving listening. Those were: Lone wolf, buddy ststem, and the Group approach methods.
We also talked about ten bad habits of listening. Those were: Evaluation, non-critical inference, plural inference, attitude, lack of attention, Wishful thinking, excessive talking, semantics, fear, and lack of humility.

REMOTIVATION

Remember the ten bad habits of listening and when you find yourself using any of them, think of the effective listening methods and you will be most effective in your listening techniques.

CLOSURE

Thank you

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Adapted from a lesson plan by: SRA Brian Vogt.

1608

NAME _____ DATE _____

Rank _____ PRACTICE ___ EVALUATION ___ GROUP _____

REFERENCES: Facts about Commonly Used Drugs, David P. Jenkins and Robert Brody, Do-It-Now Foundation, Revised Third Edition, pages 16-17.

OBJECTIVES

1. Identify the medical and nonmedical origins of the use of phenylcyclohexylpiperidine (PCP) with humans.

2. Identify two major pharmacological effects of PCP.

3. Identify two primary nonmedical uses of PCP.

INTRODUCTION
(1 Minute)

ATTENTION

If someone asked you, "What is Phenylcyclohexylpiperidine and what is it used for?" What would be your answer?

OVERVIEW

Today, we will look at many aspects of PCP in relation to its use with humans. We will look at the medical and nonmedical origins of use, two types of pharmacological effects, and two types of nonmedical use.

MOTIVATION

1. If you were asked for information about hallucinogens in general, and PCP in particular, what would you say? How much information could you provide? Because our credibility in social actions depends on what we know about drugs, our information about various drugs needs to be complete.

2. With the information we will be dealing with today, your knowledge about the drug PCP will be much more complete.

TRANSITION

First, let's take a look at some background information about PCP.

BODY (13 Minutes)

PRESENTATION

1. Identify the medical and nonmedical origins of the use of PCP with humans.

(Be sure to set-up overhead projector.)
TP #1 (Medical-Non-medical origin)

1609

a. Medical origin.

(1) Synthesis - search for a fast-acting intravenous anesthetic.

(2) Use - Analgesic

Trade name Sernyl-manufactured by Parke Davis - employed therapeutically as a Veterinary anesthetic agent.

(3) Discontinuance of because of sensory deprivation.

(a) Anxiety.

(b) Illusions.

(c) Delusional and hallucinatory phenomena.

(d) Feeling of displacement.

(e) Interference with thinking process.

b. Non-medical origin.

(1) Synthesis-inexpensive; "rip-off" chemists.

(2) Use - Appeared on the West coast in summer 1967; "peace pill" as a street drug.

(Give example of how many reports of THC are PCP derivatives.)

EVALUATION

(One evaluation question is required for each criterion objective. These questions may be used at the end of each objective or accumulated and used prior to the CONCLUSION of the lesson.)

Why was the medical use of PCP on humans discontinued?

Answer: Due to undesirable side- and after-affects.

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INTERIM SUMMARY

We've seen how the medical and non-medical origins of PCP differed, why and how they were synthesized and used, and why (medically speaking) they are no longer used.

TRANSITION

Having looked at the origins of use, now let's look at the effects which were noted from this use.

PRESENTATION

2. Identify two primary pharmacological effects of PCP.

TP #2 (pharmacological effects)

a. Anesthetic.

(Affect skeletal muscle, central nervous system)

(1) Limited CNS depression - effects unlikely any other.

(2) Sensory cortex and midbrain.

Eyes, knee reflexes not affected.

(a) Calming - cataplletic and stuper, convulsions.

(b) Respiration and bollod pressure - only with overdose (high potential).

(c) Sense discrimination pain, touch, sensory deprivation (foot asleep).

(3) Synergistic with alcohol.

(4) Decreased body temperature - shock, death.

(5) Poison - vomiting, coughing, convulsions.

b. Hallucinogenic - initially euphoric.

(Give examples)

(1) Gross hallucinations.

(a) Paranoia.

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(b) Anxiety, restlessness.

(2) Interference with thinking (feelings of displacement).

(3) Disturbing after-effects.

(a) Apathy.

(b) Feeling of depersonalization.

(c) Thought disorder.

(d) Body image disturbances (floating in space).

EVALUATION

What are the two major pharmacological actions of PCP on the body?

Answer: Anesthetic and hallucinogenic.

INTERIM SUMMARY

We've seen how PCP has both an anesthetic and a hallucinogenic action on the body, and how both physical and mental functioning is affected.

TRANSITION

Because of the effects of PCP, non-medical or recreational use has developed. Now, let's take a look at two types of this use.

PRESENTATION

3. Identify two primary non-medical uses of PCP.

TP #3 (Primary non-medical uses)

a. Popular mixer with other substances.

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(1) LSD - Primary combination (usually with poor LSD).

(2) Mint, parsley - eaten or smoked.

(3) Marijuana, tobacco - sprayed, smoked.

b. Substitute for other drugs. Relate story of "Do It Now" user describing PCP "trip."

(1) Mescaline.

EVALUATION

What are two primary non-medical uses of PCP.

Answer: Mixer and substitute.

CONCLUSION (1 Minute)

SUMMARY

We've taken a look at many aspects of the drug PCP. We've seen how the origins of use for medical and non-medical purposes differ, how the anesthetic and hallucinogenic effects of the drug affect both physical and mental functioning of the body, and how many of these effects have led to such non-medical uses as a drug mixer and substitute.

REMOTIVATION

The next time you're asked for information about hallucinogens in general, and PCP in particular, you'll be able to have quite a bit to say. You'll be able to provide information which will add to your credibility and the credibility of Social Actions.

CLOSURE

If you need any additional information about this area contact:

Do-It-Now Foundation
National Media Center
Post Office Box 5115
Phoenix, Arizona 85010

Adapted from a lesson plan by: TSgt Philip J. Gerace, Jr.

1613

LECTURE METHOD PRACTICUM

EVALUATION CRITERIA

PREPARATION OF LESSON

Exceeds Requirements		Below requirements
	1. Resources	
Used two or more resources from an approved source; incoporated information into the lesson plan	Meets requirements	Below requirements. Failed to use one resource from an approved source
	2. Objectives	
	a. Appropriate Number	
Appropriate number of objectives to develop lesson topic; condition, behavior and standard clearly stated	Appropriate number of objectives to develop lesson topic.	No objectives provided or inappropriate number of objectives (too many or too few)
	b. Behavior to be Learned Specified	
Learning outcomes explicitly stated in measurable terms	Both amount and area to be covered are specified	Both amount and area to be covered are not specified
	c. Appropriate subject	
Objective(s) clearly related to an original and creative topic	Objective(s) stated is/are related to the approved area	Objective(s) stated is/are not related to the approved area
	3. Lesson Organized in Logical Sequence.	
Lesson flows; teaching steps appropriately placed to support lesson objectives; entire lesson supports the overall theme.	Teaching steps appropriately placed to develop lesson objectives; objectives and teaching steps are sequenced properly	Inappropriate placement and illogical sequence of majority of teaching steps and/or objectives; lesson is confusing
	4. Content Sufficient to Meet Objectives.	
Objectives and teaching steps fully developed with clarity such that lesson plan can easily be followed	Adequate number of teaching steps and information to develop objectives	Additional teaching steps, information needed or need to remove excess informatio

Attchment 2

1614

PRESENTATION

1. Introduction

a. Attention Gained

Students' attention gained in a creative manner; original technique; left little doubt as to focus of students' attention on subject	Students' attention adequafely focused on subject	Little or nc attempt to gain attention; content inappropriate and/or unrelated to subject matter; ineffective method of presentation

b. Motivation

Stimulating; specific reasons why the students need to apply whatever they are about to learn. Cites specific application for student learning experience	Motivation related realistic benefits of presentation to students.	Lacking or inappropriate content; little or no attempt to provide information on lesson benefits; method of presentation was ineffective

c. Overview

Clear, concise presentation of objective(s) and key ideas, free of material that distracts from focus on lesson.	Adequately explained sequence of areas to be covered.	Little or not attempt to provide information on sequence of areas to be covered.

---

2. Body.

a. Objectives Met

Information in each teaching step presented as outlined in lesson plan. Objectives taught in a manner that promotes understanding of material.	Teaching steps adequately presented as outlined in lesson plan.	Two or more teaching steps not presented as outlined in lesson plan.

b. Evaluation Step

Stimulating: creative; thought provoking questions used for each criterion objective.	Appropriate type of question(s) used; related to information given in presentation; at least one evaluation question used for each criterion objective.	No attempt to use question for evaluation purposes.

3. Clarity of Presentation.

a. Verbal Support

Appropriate credit given to references; statistics, definitions, quotes, examples etc., ENHANCED lesson.	Clarified, simplified ideas; added variety; gave emphasis	Less than effective use; appropriate length of time context, content.

b. Transition

Transitions provided logical sequence; material tied together in a smooth easy to follow fashion.	Good relationship between parts of the lesson criterion objectives, teaching steps, etc.,	Vague, abrupt relationship between points or no transition provided.

c. Interim Summary

Interim Summaries used where needed; used logical sequence; reinforcement for learning was readily apparent	Reviewed main points; related information to criterion objective	Disorderly sequence used; information not clearly related to objective(s) or failed to provide interim summary.

d. Visual Aids

Creative, original, neat, well prepared; aided greatly in information clarification	Effectively used; aided in information clarification	Less than effective techniques of use and preparation or detracted from lesson

---

4. Pacing the Lesson

a. Lesson Timing

Exceeds Requirements	Meets Requirements	Below Requirements
14.5 - 15.5	15 minute presentation 13.5 - 16.5 min	15 minute presentation less than 13 or more than 18min.

b. Internal Timing

Ideal distribution of time between lesson elements; areas covered as planned.	Balance in time distribution; areas received adequate time	Implance in time distribution; planned teaching steps and/or objectives not covered.

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c. Progression By Student Needs

Appropriate time taken to respond to students' spontaneous questions; encouraged students to ask questions; demonstrated concern for student learning.	Adequate time taken to respond to students' spontaneous questions.	Inappropriate/no response given to students' spontaneous questions; demonstrated lack of concern for student learning.

5. Instructor Qualities

a. Physical Qualities

(1) Gestures

Greatly aided the communication process; well extended; appeared natural.	Well-timed, spontaneous, definite; aided the communication process	Gestures used lacked effectiveness due to awkwardness timing, etc.

(2) Eye Contact

Continually maintained excellent eye contact throughout presentation	Eye contact with students maintained for most of lesson	Minimal or no eye contact with students due to focusing of attention on notes, or physical surroundings.

(3) Physical Mannerisms

Aided greatly to transitioning between points. Created lively, interesting lesson.	Purposeful, moved with ease; aided transitioning between points.	Awkward or distracting; lacked purpose and ease.

(4) Posture

Appropriate posture; created favorable, professional impression throughout presentation	Appropriate posture throughout lesson.	Inappropriate posture throughout majority of lesson; distracting; failed to create favorable professional impression.

(5) Poise/Dress

Appearacne created favorable impact; added much to lesson effectiveness: military/civilian Dress exeeded Air Force Standards.	Appearance created favorable impression; added to lesson effectiveness.	Appearance created unfavorable impression; detracted from lesson effectiveness

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b. Vocal Qualities

(1) Vocal Variety

Outstanding variation of vocal qualities to enhance lesson; used voice as a "Training Device" to increase effectiveness of lesson	Vocal qualities aided lesson effectiveness; force, rate, pitch, clarity in tune with meaning, emotional content emphasis	Vocal qualities detracted from lesson effectiveness lack of or excessive variation in force, rate, picth, clarity throughout most of lesson

(2) Verbal Mannerisms

Absence of complete distracting mannerisms throughout presentation, lack of slurred speech and verbal pauses - greatly added to lesson effectiveness.	Absence of districting verbal mannerisms such as verbal pauses.	Use of distracting verbal mannerisms throughout much of presentation

c. Instructor Attitude

(1) Enthusiasm

Highly motivated, demonstrated genuine interest and involvement throughout lesson	Appeared motivated throughout presentation.	Demonstrated lack of interest and involvement; lack of verbal and physic impression.

(2) Sincerity

Demonstrated genuine acceptance, belief in information; adjustments in vocal rate, pitch, gestures, body movement adjusted to content of information presented	Verbal, non-verbal expression in tone with content of information presented.	Little or no attempt to demonstrate acceptance, belief in information through verbal, physical expression

(3) Confidence

Vocal qualities, physical qualities precisely in tune with content and mood of presentation; lesson plan used extremely well. Made purposeful and easy movements from and to podium	Vocal qualities, physical qualities in tune with and mood of presentation; notes used as a guide and not as a crutch	Vocal qualities (frequent use of verbal distractions etc.) physical qualities (excessive or lack of body movement, etc.), excessive reliance on notes, greatly detracted from presentatio effectiveness.

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(4) Directness

Very effectively maintained bond with students through excellent eye contact; used "you", "we" statements to create an atmosphere of involvement with students.	Maintained bond with students through use of eye contact and "you, we" rather "I" statements.	Lack of eye contact with students throughout majority of presentation; use of "I" statements; detracted from inclusion of students in lesson.

6. Conclusion

a. Summary

Excellent review of main ideas in an orderly sequence; showed direct relationship of ideas to objective(s)	Adequately reviewed, restated main ideas in orderly sequence; related ideas to objective(s)	Relationship vague, unclear or incomplete; no orderly sequence used

b. Remotivation

Stimulating; reminded students again of the realistic application of the information presented	Capitalized on realistic potential uses of information presented	Information presented on uses of lecture material lacked realism, meaningful applicability.

c. Closure

Left little doubt; lesson over. Provided additional food for thought.	Provided appropriate, definite closure to lesson	Little or no attempt to provide definite ending; students didn't realize lesson was over.

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STUDY GUIDE AND WORKBOOK

3ALR73430B/3OLR73618/3OZR7364B- V-1

Technical Training

Drug and Alcohol Abuse Control

PRINCIPLES AND TECHNIQUES OF DRUG/ALCOHOL EDUCATION

1 August 1978

USAF TECHNICAL TRAINING SCHOOL
Lackland Air Force Base, Texas 78236

Designed For ATC Course Use

DO NOT USE ON THE JOB

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Social Actions Training Branch
Lackland Air Force Base, Texas

SW 3ALR73430B
30LR7361B/30ZR7364B-V-1
1 August 1978

PRINCIPLES AND TECHNIQUES OF DRUG/ALCOHOL EDUCATION

OBJECTIVE

Upon completion of this study guide workbook you will be able to identify instructor traits generally associated with educational presentation and proper instructor teaching techniques associated with each one; instructions on lesson planning; the requirements and research findings of the drug/alcohol education program, types of drug education messages that have been identified as generally productive and counter productive; the findings of the A.D. Little Study (1974) concerning the abuse of drugs and the effects of drug education; the report to Congress by the Comptroller General of the United States; and visual aids and their appropriate uses.

INTRODUCTION

The information contained in this study guide workbook provides the fundamental principles and techniques of drug/alcohol education. It will serve as the foundation for the methods of instructions, lecture and guided discussion, you will be using in your practicums.

INFORMATION

PRINCIPLES

Instructor Traits and Techniques

An instructor within any classroom has two primary responsibilities: to present information and to present information. Although these two responsibilities seem identical when written out, the two actually have different but related meanings.

To present information means to present knowledge on a specific topic or topics. The value of this knowledge depends on you. If the information is inaccurate, poorly thought-out, or lacks meaning for those who are listening, it will be of little value. If, however, the information is accurately and well thought-out, and has meaning for those who are listening (your audience), it will have great value.

Supersedes SW B-II-2-5, 15 April 1977.

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To *present* information also means to take your information and provide it to others. The value of this activity again depends on you. If the method of presentation is such that interest in the information is lost, then there is little value. If, however, interest in the information is not decreased, but actually increased, then the method of presentation is effective and has great value.

This first section then, will help provide you with educational tools designed to increase the overall effectiveness of your method of presentation. Although every instructor has his/her own presentation style, consideration and incorporation of specific presentation techniques can add to the value of your method of presentation.

DIRECTNESS

The concept of directness involves the following:

Conversation With Audience

Provide an enlarged, one-to-one conversation with an audience.

Speak to Individual Audience Members

Speakers should attempt to talk to each audience member regardless of group size.

Eye Contact

Maintaining eye contact with audience members is an important part of directness. Speakers should look at their audience and not away from them — such as looking at the ceiling, floor, wall, and podium. Speakers should also scan the entire group and not focus on one audience member or one section of the audience.

Pronouns

The subject matter will seem more meaningful to the audience if you will use the pronouns "we" and "you" instead of "I." For example, rather than saying "This is the information I want you to cover today." say, "This is the information we will be covering today." By changing just one word, you can increase directness or contact with your audience.

SINCERITY AND ENTHUSIASM

Enthusiasm and sincerity are contagious; thus, if a speaker wants his/her audience to be sincere and enthusiastic, he/she must demonstrate a belief in the material being presented, as well as show his/her involvement.

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Individual Interests

In order to increase your interest and enthusiasm when giving a presentation, develop your interest when planning a presentation. Select a topic for a presentation or modify a presentation in such a way that it has meaning for you.

Belief in Content

You should believe in the content and communicate this belief to your audience. It is important that you convey earnestness and conviction.

Acceptance of Information

Your sincerity and enthusiasm are the most important tools in causing audiences to accept information that you are presenting.

Helpful Aids

Make use of vocal variation, hand gestures, body movements (moving toward audience to stress a point), and posture (leaning forward), to convey your sincerity and enthusiasm.

VOCAL QUALITIES

Vocal qualities are those qualities which will create interest and not be boring to the audience. Many good lessons fail to get across because of poor speaker vocal quality.

Feedback

Consider feedback as a source of information on the effectiveness of vocal qualities. Feedback from other people will help you discover just how well you are getting across to your audience.

Maximize Interest

Be aware of vocal qualities in order to maximize interest in the information presented. Following are ways to maximize interest:

VOCAL VARIETY. Provide vocal variety as opposed to monotone.

VARY PITCH OR RATE. Vary pitch or rate according to the information covered; i.e., periods of lower pitch or slower rate add emphasis.

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Vocal Distractions

Nothing detracts from lesson effectiveness more than vocal distracting mannerisms. You should be aware of and avoid vocal distractions such as:

PACE. Extended periods of extremely slow-paced speech could be very boring while extended periods of a fast rate may tend to lose the audience.

VERBAL MANNERISMS. Make every effort to cut down on or eliminate verbal mannerisms such as "uhm," "ah," "uh," "you know," etc.

PHYSICAL QUALITIES AND MANNERISMS

Physical qualities are just as important as vocal qualities. These qualities concern the speaker's body movements and personal appearance.

Posture, Dress, Poise

Good posture, tasteful dress, and good poise should add to your presentation rather than detract from it. You should be careful not to lie on the podium, or hang onto it as if it will "get away." Naturally, if you are giving a lecture, you will not be seated unless you are physically handicapped.

Body Movement

Audiences tend to follow body movements. Too much movement is distracting. Too little movement is boring. Playing with chalk, jingling keys in pockets, or twirling pencils can also be distracting.

Movement Conveys Meaning

Body movement is useful in gaining attention, transitioning from point to point, and adding sincerity. Feedback from others regarding body movement will also be useful to you in making improvements to your method of delivery.

How to Accomplish Movements

Body movement should be purposeful and seem natural. For example, move to the chalkboard to illustrate a point, shrug your shoulders to illustrate disgust, or raise your eyebrows to show excitement and enthusiasm.

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GESTURES

Gestures can add greatly to your presentations if they are used wisely.

Should Be Natural

Some individuals are more comfortable with gesturing than others. Certain individuals cannot speak without elaborate hand and body movements. Gesturing should appear natural, as if you gesture all the time. Nothing is more distracting than robot-like movements that appear awkward and unnatural.

Should Reinforce

Gestures should reinforce, not detract from, real expression.

Experiment

Experiment with gestures. Trying on new gestures may lead to a more natural use of gestures. If you will practice with gestures, you may find that they will appear more natural and add greatly to your presentation.

USE OF NOTES

There are four important techniques regarding the use of notes. Each technique is most effective when used in a specific situation.

Reading From a Typed or Written Script

This method is effective when exactness is required (quotes, regulations, etc.). When used over long periods of a presentation, it usually results in the loss of directness, sincerity, and enthusiasm, and vocal variety, etc.

Reciting Memorized Material

Although this technique is effective for short segments (quotes, regulations, etc.), use over long periods may create awkward situations if material is forgotten.

Speaking Impromptu

Although this method is effective when there is great familiarity with the material to be covered, it is a difficult method to use when specific guidelines need to be followed or specific informational objectives need to be met.

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Speaking Extemporaneously

Speaking extemporaneously from an outline or lesson plan is probably the most effective overall technique. Information is outlined in an organized manner with key words or phrases being used instead of a sentence-after-sentence script. This method provides for a great deal of instructor flexibility while insuring that specific educational objectives are met.

USE OF VERBAL SUPPORT

There are many types of support material that can be used to improve the effectiveness of a presentation.

Purpose

The purpose of support material is to provide clarification, explanation, add variety, and show proof.

Types of Support Material

Support material includes examples to illustrate a point, comparisons, statistics, quotations, restatement, and repetition.

Use of Support

The key to using support material is that it enters the planning stage of your presentation. On-the-spot verbal support normally doesn't have the same quality as preplanned verbal support. Support material should be used whenever clarification or emphasis of ideas is needed.

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EXERCISE 1

The following exercise is designed for individual review and self-evaluation purposes.

Match each of the following instructor traits with its proper method of implementation or use.

a. Directness
b. Sincerity/enthusiasm
c. Vocal qualities
d. Physical qualities/mannerisms
e. Gestures
f. Use of notes/script
g. Use of notes/memorization
h. Use of notes/impromptu
i. Use of notes/lesson plan
j. Support material

____ 1. Select a meaningful topic for presentation.
____ 2. Maintain eye contact. Use pronouns "we" and "you."
____ 3. Plan their use prior to use.
____ 4. Use when exactness is required.
____ 5. Use for short segments.
____ 6. Experimentation leads to more effective use.
____ 7. Use to add sincerity or change area of interest.
____ 8. Use variety.
____ 9. Avoid use when objectives need to be met.
____ 10. Use key words and phrases.

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ADVANTAGES AND DISADVANTAGES

Although, in recent months, the guided discussion method of instruction has received greater attention than the lecture method, the lecture method is still a useful method of instruction in terms of drug and alcohol educatior.. Because each method of instruction has unique positive and negative qualities, each method of instruction is most useful when applied to specific types of educational situations. The lecture method of instruction, for instance, is most useful when information or factual-type data needs to be dealt with. It is not as effective in dealing with attitudes or emotions as is the guided discussion method.

ADVANTAGES

There are three advantages of using the lecture method of instruction. These advantages are:

Saves Time

A great deal of information can be covered in a short period of time.

Saves Manpower

One instructor can convey information to an almost unlimited number of students.

Supplements Other Instruction Methods

The lecture method can be used with other methods of instruction; i.e., before conducting a guided discussion with students, a short lecture can be used to provide a background of information for discussion.

DISADVANTAGES

The lecture method also has four disadvantages. They are:

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Limited Participation

Participation by students is usually limited to asking or answering questions. Students are given little opportunity to share their knowledge.

Difficult to Measure Student Understanding

About the only way to find out if students are absorbing information is to check non-verbal feedback (facial expressions, body positions, etc.), or to ask specific questions.

Difficult to Maintain Interest

Depending on the ability of the instructor or the relevance of the material, the interest level in a lecture may be very high or very low.

Difficult to Teach Skills

Although this method can provide background information relating to the performance of skills (counseling, etc.), the actual performance of skills cannot be dealt with effectively through the use of the lecture method. Other methods, such as demonstration performance, case situation, or other methods, are more effective in dealing with skills.

LESSON PLANNING

Definition and Purposes of Lesson Planning

The following information taken from AFM 50-62 provides useful information to consider concerning the topic of lesson planning.

> As is true in most activities, the quality of planning usually determines the quality of the results. Every successful executive or professional person knows that the price of excellence is careful planning. The lawyer spends hours in preparing a case before he/she presents it in the courtroom. The minister does not ad-lib his sermon; he/she plans days or weeks in advance. In preparation for the big game, the coach spends hours in planning the plays and

in watching his team execute them. Should such a complicated process as learning be attempted with less attention than is given to other important activities? The answer is obvious – the effective instructor devotes much time and energy in preparation for each classroom session.

To ensure the greatest probability of learning, the instructor carefully selects and arranges activities that produce desired changes in the behavior of his/her students – behavior that is consistent with their abilities and interests. Only through careful planning can he/she be certain that he/she includes all necessary information and properly organizes it to achieve his/her lesson objective.

DEFINITION

Although there are many definitions of a lesson plan (depending on the source of information), the most complete and all-inclusive definition is: A guide for teaching in which information and activities are organized so that lesson objectives are achieved. The most important idea in this definition, is that a lesson plan is a guide in which organization leads to the achievement of lesson objectives or, specifically, what students are to be able to do or know.

PURPOSES

There are three purposes of using a lesson plan. These purposes are as follows:

Standardization of Presentation

Required objectives are met in your lesson and they are met from lesson to lesson because the information is standardized or basically the same. This does not mean that instructor flexibility has a lesser role. Because you know ahead of time what specifically needs to be covered, you can build your own individual instructor style around your predetermined guidelines. Also, since your ideas are properly developed, you're less likely to run short of time or overtime because you have preplanned your ideas. They are developed neither too little nor too much.

Building of Instructor Confidence

Although there is no sure-fire guaranteed way of building confidence, use of a lesson plan helps considerably. When preparing a lesson plan, you become more familiar with the information you present. By becoming more familiar with the information, you should have greater confidence when you actually have to present it. After all, it's no longer new material; you've already invested time in working with it.

Logical and Comprehensive Development

The information you present to students will seem more clear because your ideas are interrelated and flow from one to another. There is no sense of "choppiness" or feeling on the part of students that, somehow, your ideas just don't seem to fit together. Some examples are: whole-part-whole, known-to-unknown, simple-to-complex, etc.

STEPS TO LESSON PLANNING

These steps are essential to effective lesson planning and if followed will increase the effectiveness of your lesson.

DETERMINE THE LESSON'S OBJECTIVES

Before you begin to prepare a lesson, you should first determine what you want to accomplish.

Purpose

Clearly define what each student is to know or be able to do as a result of what you teach him/her.

Objectives

Construct objectives to specify precisely what the outcome or result of your instruction is to be in behavioral terms. Objectives consist of three parts:

CONDITION. Under what circumstances the student learning will take place. It encompasses specific information or materials that students will be provided with in order to accomplish their learning task. Sometimes referred to as the "givens."

BEHAVIOR. Specifically, what students are to accomplish. The key, here, is the terms "observable" and "measurable." If your goal is to have students "know" or "understand" a particular skill or particular body of knowledge, both you and your students will probably have difficulty in determining what is to be learned, what is to be accomplished. After all, how can you tell if somebody "understands" or "knows" a skill or information?

If, however, your goal for student learning due to your instruction is clearly defined through the use of such specifically observable and measurable terms as "identify," "define," "list," "state," etc., then what is to be accomplished, and what is to be taught, is more easily understood.

STANDARD. The standard determines how well you want your students to learn the information you are presenting to them; or how well they are to accomplish what you want them to accomplish. Perhaps another way of looking at standard, is that standard refers to the degree of learning desired.

Example of an Objective

In order to make this information on objectives clearer, let's take a look at an example. Suppose you want your students to learn something about counseling skills. If you state that you want students to "know some counseling techniques," you haven't clearly defined what students are to learn and what you are to teach. If, however, you state that "Given the information on Gestalt counseling techniques, each student will identify four techniques of counseling at the 100-percent level of proficiency," you have clearly defined what is to be learned and what is to be taught. The condition of this objective (1) states that students will be given information on Gestalt counseling techniques. The behavior (2) states that the goal for student learning is to identify four techniques while the standard (3) states that students will have to identify all four techniques.

School Requirement

While you are at this school, the main concern (and all that will be required) is the behavior portion of an objective. Whenever writing the behavior portion, check to make sure that you have chosen an observable and measureable term. Specifically describe what you want students to accomplish (identify, list, describe, etc., rather than know, understand, etc.), and be sure that you specify the amount that you want students to accomplish (four skills, three techniques, etc., rather than some skills, a few techniques, etc.).

With the use of lesson objectives, you should begin to see that what is to be learned and what is to be taught become much clearer.

CONDUCT RESEARCH

Research is an integral part of any good planning. Research will insure that the information that you are presenting is accurate, precise, and up to date.

Obtaining Information

Obtain information concerning selection and development of lesson topics from the following sources:

SELF. Consider those areas which interest you and those areas in which you would like to present information. Write down ideas that you already are aware of.

OTHER INDIVIDUALS. Contact your friends, "recognized subject matter specialists," or other individuals concerning the selection or development of lesson topics.

VARIOUS INFORMATION SOURCES. Read or scan over various books, pamphlets, etc., for ideas which you may want to use. These sources can often supply ideas that may not have come to mind as possible lesson topics. Make adequate use of the library facilities for periodicals, newspapers and books for use in your topic selection.

ORGANIZE MATERIAL

Organizing simply means to outline the presentation, or to create a lesson plan. (This will be described in the next objective.)

Major Points

Identify major points of information as lesson objectives.

Subpoints

Identify subpoints as teaching steps.

Outline Format

Use standard Air Force outline format and numbering/lettering system.

EXAMPLE:

OBJECTIVE

1. Identify characteristics of the five progressive stages of alcoholism.

    a. Prealcoholic stage

        (1) Begins to drink

            (a) Frequents bars
            (b) Home consumption becomes more

        (2) Appearance deteriorates

            (a)
            (b)

    b. Early stage

(Follow this format throughout the remainder of your lesson.)

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SELECTING INSTRUCTIONAL AIDS

If you have prepared a good lesson, you will want to present it in such a fashion as to maximize benefits. In order to accomplish this feat, you should be very selective in choosing instructional aids.

Selection Process

Consider various types of instructional aids such as slides, transparencies, charts, and chalkboard.

Support for Lesson

Determine those areas of the lesson in which instructional aids would be most beneficial to support presentation of information.

EXERCISE II

The following exercise is designed for individual review and self-evaluation purposes.

1. Rewrite each of the following behavior portions of objectives so that they more clearly define what students are to accomplish as a result of your instructions.

   a. Know some effects of marijuana use.

   b. Understand four symptoms of barbiturate overdose.

   c. Identify many causes of alcoholism.

2. You may want your students to know something about three types of theories regarding possible causes of alcoholism (physiological, psychological, cultural). How would you write the behavior portion of a criterion objective using this information and what would your major teaching steps be?

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MAJOR PARTS OF LESSON PLANS

You will be graded (in each of your three lecture method practicum presentations) according to the format described here (and in your *Lecture Method Practicum* handout). You should follow this format exactly when designing your lesson plans. All standardized packages used in the field also follow this same format.

INTRODUCTION

There are three major parts to the introduction of a lesson plan:

Attention Step

The attention of students should be gained and focused on the content of the lesson. To merely gain the attention of students is only half the task. Your means of gaining student attention (joke, quotation, statistic, an original idea, question, etc.) should be related to the content of the lesson.

Motivation Step

Students should be provided with information concerning realistic benefits of the lesson. In this way, students are provided with reasons for wanting to listen and wanting to learn. This step should be considered one of the most important in your presentation. Tell the listeners why it is important for them to listen to what you have to say.

Overview Step

Clearly explain the sequence of areas to be covered in the lesson, and relate these areas to each other and the overall objective or purpose of the lesson. Besides presenting students with a brief statement of areas to be covered within the presentation, they should also be provided with a statement as to how these areas are interrelated. In this way, students can more clearly see the purpose of the lesson and the way in which this purpose will be achieved.

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Transition Step

The transition step consists of one or two sentences used to smoothly tie information given in the introduction to information in the body of a lesson. It provides a lead-in for the information to be taught.

BODY

The body consists of information to be presented in the lesson.

Purpose

Presentation of information in order for objectives to be met.

Format

A two-column organizational format is used.

LEFT COLUMN. The left column contains information which is required to be taught. Included in this column are objectives and teaching steps. Evaluation questions are also included in this column. Remember, any teachable material goes on the left. The left column is the teaching outline.

RIGHT COLUMN. The right column contains information on how the information in the left column will be taught; i.e., personalization. This column contains any information regarding verbal support (examples, quotes, etc.), visual support (when to show a particular slide, transparency, etc.), and any personal notes or guidelines regarding information in the left column. This column also contains interim summaries and transitions which are required between each objective.

CONCLUSION

The conclusion is the final part of your lesson plan. It, too, has three major steps.

Summary

This step is used to review the main ideas covered in a lesson and to relate them to the overall purpose of the lesson (objectives). In the summary you retell the students what you taught them.

Remotivation

Again, information is presented on realistic benefits of the lesson. Students are left with information on why they should remember what was presented.

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Closure

This step consists of a statement which provides an appropriate, definite ending to a lesson. Students clearly realize that the lesson is over.

Examples of full lesson plans are given in the *Lecture Method Practicum* handout.

EXERCISE III

The following exercise is designed for individual review and self-evaluation purposes.

Match each of the following parts of a lesson plan with its appropriate description.

INTRODUCTION
- a. Attention Step
- b. Motivation Step
- c. Overview Step
- d. Transition Step

BODY
- e. Left-hand column
- f. Right-hand column

CONCLUSION
- g. Summary
- h. Remotivation
- i. Closure

_____ 1. Statement that provides an appropriate, definite ending.

_____ 2. Information that is required to be taught (criterion objectives, teaching steps, etc.)

_____ 3. Information on areas to be covered and the way these areas are interrelated.

_____ 4. Review of main ideas covered and their relation to the purpose of the lesson.

_____ 5. Realistic benefits of the lesson; why students should remember what was presented.

_____ 6. Statement that gains student interest and related it to the content of the lesson.

_____ 7. Realistic benefits of the lesson; why students should listen to the lesson.

_____ 8. Sentence(s) used to tie two major lesson plan parts together.

_____ 9. Information on how to teach what is required to be taught; personalization.

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DRUG EDUCATION PROGRAM OBJECTIVES

The five objectives of the USAF Drug Education Program listed below support Air Force policy regarding the problem of drug abuse, and contain guidance for base-level education programs. The Air Force is concerned with the prevention and elimination of drug abuse primarily because of its incompatibility with military standards necessary for mission accomplishment. The Air Force is also concerned with the well-being of its people, and believes in preventative education. The guidelines for drug education provided in these objectives clearly express these concerns.

OBJECTIVES

These are the drug education program objectives, as defined by the Air Staff. When you conduct drug education, you should plan your presentations so that you do the following.

Dangers

Emphasize the physiological and psychological dangers inherent in drug abuse.

Inconsistencies

Stress the inconsistency between drug abuse, military standards and responsibility, and national security, as well as the implications of drug abuse in security clearance determinations, and line-of-duty (LOD) determinations.

Alternatives

Emphasize positive alternatives to drug abuse, especially as relating to the local area.

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Disciplinary Action

Explain the disciplinary actions which may result from drug abuse.

Evaluation of Attitudes

Provide opportunities for the evaluation of various attitudes on the subject of drug abuse. To do this, stress the relationship of this objective to Values Clarification, and use group facilitation techniques in the educational setting. You may ask the question, "How are attitudes of the audience important to the instructor?" Answer: They provide knowledge about your audience and allow you to tailor your presentation.

ALCOHOL EDUCATION OBJECTIVES

The educational guidelines specified by these objectives reflect Air Force guidance toward the problem of alcohol abuse. Although decisions regarding the use of alcohol are each individual's concern, the abuse of alcohol – which results in a negative impact on military standards or individual well-being (primarily public behavior and duty performance) – is the Air Force's concern.

OBJECTIVES

Dangers

Emphasize the physiological and psychological dangers inherent in alcohol abuse.

Inconsistency

Stress the inconsistency of alcohol abuse with national security, military responsibilities, and job performance.

Consequences

Stress the possibilities and consequences of misconduct or medical complications resulting from alcohol abuse.

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Early Identification

Stress the need for early identification of job performance or behavior problems which may be due to alcohol abuse.

Problem Recognition and Treatment

Stress the need for commanders and supervisors to assist problem drinkers and alcoholics in recognizing and acknowledging their problems and seeking treatment and rehabilitation.

Avoid Shielding

Stress the importance of understanding that shielding problem drinkers, by tolerating poor performance, clearly contributes to the individual's condition by delaying his/her entry into rehabilitation. However, if individuals fail to correct their performance (by refusing assistance through this program or otherwise), they should be dealt with through disciplinary procedures.

Acceptance of Recovered Alcoholics

Promote the acceptance of recovered alcoholics into the military community.

Preventable and Treatable

Promote the acceptance of the fact that alcoholism is preventable and treatable.

Assist the Family

Encourage assisting the spouse and children of alcoholics when facilities permit or adequate civilian resources are not available.

EXERCISE IV

Complete the following exercise.

The numbered items on page 21 refer to which one of the following:

a. Alcohol education objectives

b. Drug education objectives

c. Both a and b

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Exercise IV — Continued

_____ 1. Promote acceptance of the idea that the problem is preventable and treatable.

_____ 2. Promote acceptance of the individual with the problem back into the military community.

_____ 3. Emphasize physiological and psychological dangers.

_____ 4. Explain the disciplinary actions that may result.

_____ 5. Stress the need for early identification.

_____ 6. Provide opportunities for the evaluation of various attitudes.

_____ 7. Stress the possibility of misconduct or medical complications.

_____ 8. Assist the spouse and children.

_____ 9. Stress the inconsistency with military standards and responsibilities, and national security.

_____ 10. Stress the need for commanders' and supervisors' assistance.

_____ 11. Emphasize positive alternatives.

_____ 12. Stress the effects of shielding the problem.

COUNTERPRODUCTIVE MESSAGES

Because many drug education programs contained information that had no positive effect or were counterproductive in nature, in 1973 the Special Action Office for Drug Abuse Prevention (SAODAP) conducted research, and released a series of guidelines for drug abuse education. These guidelines were subsequently endorsed by the National Institute on Drug Abuse (NIDA), the National Coordination Council on Drug Education, and other organizations. Presently, the DOD Media Committee uses these criteria to choose films and other media to be used in DOD drug/alcohol education.

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The following kinds of messages (counterproductive approaches) have been found to be generally counterproductive and should be excluded from drug abuse education programs.

ALWAYS — The use of drug X always causes condition Y.

NEVER — The use of drug X never causes condition Y.

DRUGS THE ONLY PROBLEM — Drugs are the only problem.

ONLY ILLEGAL DRUGS ABUSED — Only illegal drugs are abused.

YOUTH PROBLEM — Substance abuse is exclusively a youth problem.

SCARE TACTICS — Any message couched in terms which tend to overstate risks and make fear the main deterrent to future use.

ANTI-DRUG — We say, "You should not use (all drugs or any specific drug)."

TREATMENT MODALITY — Presenting only one type of treatment modality as the "answer."

STEREOTYPES — Use of stereotypes for characters and settings — only minorities as abusers and pushers, drug abusers as hippies, the alcoholic as a skid row bum, etc.

DEMONSTRATING USE — Demonstrating the use or method of administration of illegal drugs; i.e., showing glue-sniffing, or how to "mainline."

PRODUCTIVE MESSAGES

Instructors need to be aware of the messages (approaches) that are suggested by NIDA as being productive for education classes as this will enhance the effectiveness of your educational programs. The DOD Media Committee has adopted these criteria in determining what drug/alcohol education materials should be used in the services. This should be your guide in preparing drug/alcohol education lessons.

The following kinds of messages (productive approaches) have been found to be productive and should be included in drug education programs.

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DRUG EFFECT DEPENDS — The effect of a drug is a function of the dosage, the method of administration, the frequency of use, the individual, and the environment.

COMPLEX PROBLEM — The alcohol and drug problem is complex. There are no easy answers. No two drug users are alike.

INCONSISTENT POSITION — Society has an inconsistent position regarding the use of chemicals to alter an individual's mood. Some, tobacco and alcohol, are legal, while others are illegal.

SOCIAL PROBLEM — Substance abuse is a social problem, not just a medical problem. Therefore, we cannot reasonably expect to find only a medical solution to the problem.

POSITIVE IMAGES — Everyone, especially young people, need positive images of persons who chose a nonchemical lifestyle rather than the reinforcement of existing stereotypes of dead-end addiction.

SOLUTION — People can help to solve the substance abuse problem by promoting the following conditions:

Better communication — It is important for people to talk and listen to each other.

Feeling of control — People need to have a feeling of control over their own lives, have a purpose in living, and accept responsibility for their lives.

Alternative lifestyles — There needs to be an acceptance of the validity of legitimate alternative lifestyles.

Value structures — We should have value structures which deemphasize immediate gratification.

SPECIAL FILMS — Films should be selected for target audiences, with emphasis on decision-making, attitudes, and value clarification.

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EXERCISE V

Complete the following exercise.

Which of the following statements reflect:

a. Productive messages (approaches)?

b. Counterproductive messages (approaches)?

_____ 1. Only illegal drugs are abused.
_____ 2. Drug X always causes condition Y.
_____ 3. Drug X never causes condition Y.
_____ 4. Drug abuse is a social as well as medical problem.
_____ 5. The drug/alcohol problem is complex.
_____ 6. Presenting one type of treatment method.
_____ 7. Saying "You should not use drugs."
_____ 8. People can help solve the drug problem.
_____ 9. Using scare tactics or fear.
_____ 10. Providing positive nonchemical images.
_____ 11. Society's position regarding chemicals is inconsistent.
_____ 12. Drug abuse is exclusively a youth problem.
_____ 13. Drugs are the only problem.
_____ 14. Using stereotypes for interviews, settings.
_____ 15. Demonstrating proper use of illegal drugs.
_____ 16. The effect of a drug is the function of many factors.

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FINDINGS A.D. LITTLE STUDY

In 1971, the Department of Defense (DOD) began developing programs to deal with prevention and control of drug abuse in the military. After nearly two years of operation, the DOD contracted with Arthur D. Little, Inc., to evaluate military programs designed to prevent and control drug abuse.

Although the entire study deals with such areas as program administration, drug education, and drug abuse identification, treatment, and rehabilitation, the findings reported here deal only with the area of drug education.

Because the information within this study was accumulated, evaluated, and reported DOD-wide, no comparison of findings between the different services is available.

FINDINGS CONCERNING DRUG ABUSE IN THE MILITARY

Remember that these findings are DOD-wide, and do not reflect just the implications of drug abuse in the Air Force.

AGE — Primarily persons ages 21 and under.

GRADE — Primarily youth of the junior enlisted population.

EDUCATION — High school dropouts were the only educational group with a disproportionately higher rate of drug use.

DRUGS OF ABUSE (January - March, 1974. E-1's - E-5's)

Marijuana — 38 percent; Amphetamines — 15 percent; Hallucinogens — 14 percent; Cocaine — 11 percent; Other "uppers" — 11 percent; Barbiturates — 11 percent; Other "downers" — 11 percent; and Opiates — 7 percent.

LOCATION OF ABUSE — Range of use, from installation to installation, varies considerably. Locational differences (United States versus Pacific versus Europe) are quite small.

CONSISTENCY OF ABUSE — Where use of drugs is high at a particular installation, it is high across all drug classes. Where it is low, it is low across all drug classes.

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INITIATION OF ABUSE IN THE MILITARY — Sixty-five percent of all drug users used drugs before entering the service.

CHANGE IN ABUSE — Decrease in use when comparing preservice drug use to inservice use. Marijuana use, however, seems to have increased somewhat. Number of drug users may be holding steady or increasing slightly. Very heavy use of drugs is decreasing, but slight or moderate use is up somewhat.

COMPARISON OF ABUSE — Drug use in the service (in terms of percentage "ever used") seems higher than civilian student use (in some cases, substantially so). However, directly comparable civilian data (i.e., predominantly male, aged 18 - 21, comparably educated) is not available.

EDUCATIONAL IMPLICATIONS

The educational implications of the findings are as follows:

TARGET POPULATION — Drug abuse education needs to be geared toward younger enlisted service members.

MARIJUANA — Because marijuana is the most frequently abused drug, up-to-date information regarding the effects of its use (e.g., legal, psychological, etc.) is needed.

SURVEYS — Prior to drug education classes, surveys are needed to determine the extent of installation drug usage.

EXERCISE VI

Complete the following exercise.

Which of the following statements regarding drug abuse in the military and educational implications are:

True? (T)

False? (F)

_____ 1. Drug abusers are primarily younger people.

_____ 2. Drug abusers are primarily in the upper officer population.

_____ 3. Well-educated people have a higher rate of drug abuse.

_____ 4. Opiates are the most frequently abused drugs.

_____ 5. Range of abuse from installation to installation varies considerably.

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Exercise VI — Continued

_____ 6. High abuse of one drug at a particular installation indicates high abuse of all drugs.

_____ 7. The majority of drug abusers start abusing drugs after entering the service.

_____ 8. When comparing preservice to inservice drug use, marijuana use has decreased.

_____ 9. Drug use in the service is lower than civilian use.

_____ 10. Drug abuse education should be geared toward younger enlisted service members.

_____ 11. Because of the frequency of marijuana abuse, up-to-date educational information about its effects is not needed.

_____ 12. Surveys to determine the extent of installation drug usage are needed prior to drug education.

DRUG EDUCATION FINDINGS

Air Force Social Actions instructors need to be aware of the *A. D. Little Study* concerning drug education program methodology and its implication on the drug education in the military in order to avoid the pitfalls that have plagued previous educators in drug abuse.

EDUCATIONAL METHODOLOGY

Methodology refers to the way that education has been presented in the classroom.

Approaches

Approaches to education consisted of the following:

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STANDARDIZED APPROACH. A standardized approach includes using lectures, literature about drugs, movies, or slide shows.

PARTICIPATORY APPROACHES. Participatory approaches are such things as discussions or "rap" sessions, which are also used with some frequency.

Messages

Messages most frequently presented are concerned with giving basic facts about drugs, warnings of punishment for drug use, and the facilitation of personal understanding in order to encourage a decision not to use drugs.

Exemption Policy

Knowledge about the exemption policy (Limited Privileged Communication Program (LPCP)) and rehabilitation services was often not communicated in most of the services surveyed.

EDUCATIONAL EFFECTIVENESS

Findings regarding the effectiveness of education consisted of the following:

Prevention

Efforts toward prevention of drug abuse consisted of the following:

EXPOSURE. Exposure to drug education is apparently related to the prevention of the use of at least some drugs.

PREVENTATIVE EFFECTS. The strength of preventive effects does not increase with increasing amounts of drug education.

POTENTIAL USERS. Drug education may inform potential users of the dangers of drugs which were not previously realized and which may, in some cases, deter them from use.

Drug Choice

Drug education's main effect is on the choice of drugs, rather than on the more basic decision of whether or not to use drugs at all.

Correction of the Drug Problem

Correction effectiveness consists of the following:

RELATIONSHIP. Drug education is generally unrelated to the correction of drug use, once started.

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EFFECTIVENESS. Drug education *is effective*, even though it does not influence great numbers of users to stop using drugs.

PERCENTAGES. Approximately 150 individuals in the sample population of over 12,000 (or about 1.2 percent) reported that drug education had caused them to stop using drugs.

EDUCATIONAL RECOMMENDATIONS

Recommendations from the findings consist of the following:

Continuation of Education

Drug education can be effective and should be continued on a regular basis to all service personnel.

Audiences

Drug education audiences should be differentiated by characteristics relating to type and intensity of drug use. *

Emphasis

Special emphasis should be placed on education for new recruits and transferees. *

Evaluation Techniques

Greater use should be made of evaluation techniques (service and installation level) to diagnose types of drug problems present, and to discover which types of approaches work best.

Alternatives

Alternatives to drug use is a useful topic and needs to be coupled with information concerning the utilization of alternatives at each installation.

Exemptions

Greater emphasis is needed in presenting information on exemption (LPCP) and rehabilitation.

Senior Members

Education addressed to senior noncommissioned officers (NCOs) should be primarily focused on basic facts about drugs and generally changing their attitudes toward drug use. *

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Focus

Education addressed to officers need not focus on attitude change, but should focus on drug facts and the basic policies and services of the drug program. *

Instructors

Only individuals who have a desire to instruct should be channeled into the area of drug education.

Installation-Level Programs

Installation-level programs should concentrate on presenting the facts about drugs to audiences of nonusers and transferees. *

* *These recommendations have shaped the current event-oriented standardized education packages now used in the field.*

EXERCISE VII

Complete the following exercise.

Which of the following statements regarding drug education are:

True? (T)

False? (F)

_____ 1. The major educational approaches used are standardized or participatory approaches.

_____ 2. Knowledge about the exemption policy (Limited Privileged Communication Program (LPCP)) is always communicated.

_____ 3. Exposure to drug education is related to the prevention of drug use.

_____ 4. Drug education's main effect is on the choice of drugs to abuse.

_____ 5. Drug education's main effect is on the correction of drug abuse.

_____ 6. Drug education should be given only to new recruits and transferees.

_____ 7. Information on local alternatives to drug abuse is a necessary topic.

_____ 8. Drug education addressed toward officers and NCOs should be the same.

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Exercise VIII — Continued

_____ 9. Individuals with an interest only in drug counseling should also be used to conduct drug education classes.

_____ 10. Evaluation techniques should be used to obtain information on installation drug problems.

_____ 11. Sufficient emphasis is currently placed on exemption (LPCP) and rehabilitation information.

_____ 12. Members of drug education audiences should be similar regarding type and intensity of drug use.

REPORT TO CONGRESS BY THE COMPTROLLER GENERAL OF THE UNITED STATES

This report, submitted to DOD in late 1975, involved a study conducted by the GAO into three general areas: (1) The relative impact drugs and alcohol have on military performance; (2) The services' compliance with directives and policies on identifying drug and alcohol abusers; and (3) The scope of treatment and rehabilitation services provided or made available to individuals with drug and alcohol problems. The GAO study group visited 36 military bases, worldwide, and interviewed 276 commanders, 107 medical authorities, 357 patients in drug and alcohol rehabilitation programs, and significant others involved. The services' compliance with applicable DOD policies, practices, and procedures were examined; records (including patient files) relating to the management and administration of drug and alcohol programs were reviewed; and pertinent statistics concerning the impact of drugs and alcohol on the military were obtained.

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GAO STUDY RESULTS

Findings

Precise measurements as to the actual size of the military's drug and alcohol problems or the degree of impairment drugs and alcohol have on military performance were not fully assessed by the study. However, based on the information obtained, two major findings were brought forth and supported by the study.

First, the study found that alcohol abuse is more prevalent among military personnel than drug abuse, and that it impairs the efficiency and effectiveness of military performance more than illegal drug use. This finding was supported in studies conducted by both the Army and Navy. An Army study completed in December, 1972, showed that 20 percent and 30 percent of officers and enlisted, respectively, are heavy or binge drinkers, while an additional 17 percent and 35 percent, respectively, have drinking problems. A 1972 Navy study estimated it loses about $52 million annually from absenteeism, decreased efficiency, and poor decision-making, due to drinking. Since this figure excludes certain costs (e.g., hospitalization), it is considered to be very conservative.

Second, despite the apparent greater impact of alcohol abuse, DOD has placed more emphasis on its drug control programs than on its alcohol programs. For fiscal years 1972 through 1975, funding levels to support the services' drug programs were over 6 times greater than for its alcohol programs. For fiscal year 1976, the ratio of drug to alcohol funds is estimated to be four to one. The general trend in the Navy and Air Force has been to decrease drug funding and increase alcohol funding. The Army, however, has continued to increase its drug funding over alcohol.

Conclusions

Although DOD has made progress in coping with the drug and alcohol problems of military personnel, the study concluded that significant problems still persist, which require additional actions. Conclusions regarding the study indicated the following deficiencies in DOD's management of its drug and alcohol programs:

1. DOD has not sufficiently recognized the severity of its alcohol problem.
2. DOD's approach to its drug problem is not as effective as possible.
3. DOD needs an information system to accurately gage the size of its drug and alcohol problems and to provide feedback on the effectiveness of its actions in correcting them.

Recommendations

In order to improve the apparent deficiencies in DOD's drug and alcohol programs, the study offered several recommendations. Recommendations were indicated specifically for the alcohol and drug programs and the information system.

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ALCOHOL. In the alcohol area, the study recommended the following course of action:

Increase Efforts. Increase alcohol education efforts to effect greater awareness and change attitudes among military personnel.

Alcohol Consumption. Reduce or eliminate practices encouraging alcohol consumption.

Alternatives. Provide alternatives to alcohol use by encouraging and supporting activities not centered about drinking.

Strengthen Existing Programs. Strengthen programs for identifying, treating and rehabilitating individuals with alcohol problems.

DRUGS. The study's recommendations in the drug area included the following:

Urinalysis. Reevaluate the desirability of the present urinalysis testing program. *

Exemption Policy. Provide more emphasis on the drug user exemption policy, in order to improve its credibility and success.

Rehabilitation. Instruct services in the levels of rehabilitation necessary for particular drug problems; especially emphasizing the best approaches in dealing with the marijuana problem.

INFORMATION. The study recommended the establishment of a DOD-wide information system. This system would provide the necessary information and feedback for DOD to improve the overall management of its drug and alcohol programs.

* *This recommendation served to encourage our current revised urinalysis testing program.*

Closure

DOD was in general agreement with GAO's conclusions and recommendations and shared concern over the prevalence of alcohol and its impact on military personnel. DOD did, however, question whether alcohol abuse was more serious than drug abuse. In addition, DOD disagreed with GAO's recommendations on the need to increase alcohol education, reevaluate the urinalysis program, and improve the information system.

GAO, however, feels that the results of its study, as presented, are valid. GAO's view seems to be supported by two independent consultant studies performed by Arthur D. Little, Inc., and the System Development Corporation released May, 1975, and September, 1975, respectively.

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EXERCISE VIII

Complete the following exercise.

1. What was the GAO's finding regarding alcohol abuse among military personnel?

2. Which program did the GAO feel received more emphasis?

3. What were the three conclusions the GAO reached concerning DOD's management of its drug and alcohol programs?

4. What was GAO's recommendation concerning DOD's need to gage the size of its drug and alcohol problems and obtain feedback on the effectiveness of its actions to correct them?

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VISUAL AIDS
APPROPRIATE USES OF VISUAL AIDS

Research has indicated that learning occurs 75 percent through sight and only 13 percent through hearing. Research has also shown that visual aids can add to learning retention by as much as 80 percent. It is because of these and other reasons that visual aids are important in any educational lesson.

Before using any visual aid, two things should be considered: Which information in your lesson should be supported by a visual aid, and which type of visual aid would be most appropriate.

In determining those areas of information in which a visual aid would be most beneficial, consider those areas in which a visual aid would be the most beneficial in terms of clarification or understanding.

In determining which visual aid is the most appropriate, characteristics of each visual aid should be considered.

CHALKBOARD

One of the most widely used visual aids is the chalkboard. We will be discussing the misuses and suggested uses of the chalkboard in this section.

Improper Use

Improper use consists of the following:

TALKING TO BOARD. Individual speaking while facing the board. There can be no eye contact while facing the board and not the audience. Instructors cannot observe the reactions of the audience to their comments while talking to the board.

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STANDING IN FRONT OF BOARD. Individuals explain what is written while standing in front of the chalkboard. This is extremely distracting since the audience cannot see what is written on the board.

INVALID INFORMATION. Unnecessary and often confusing information is not erased. Information that is no longer needed should be erased.

ILLEGIBLE. Information presented on the chalkboard is illegible because it is poorly written. Perhaps, the best method of writing on the chalkboard is to use the block style of printing.

Suggested Chalkboard Use

Being aware of the improper use of the chalkboard alone is not sufficient. It is also important to know how to use the chalkboard effectively. Following are some helpful suggestions:

ERASING. Erase the board horizontally before starting to write in order to form writing guidelines.

ADD VARIETY. Add variety by having words, symbols, etc., written on colored paper and then taped to the chalkboard. Another suggestion would be to use colored chalk, but be very careful as some of the colors are rather light and difficult to read.

35mm SLIDES

Another visual aid that you may want to consider using is the 35mm slide projector. The use of slides provides a more permanent type of visual aid for continuous use.

Use of Projector

Before using the projector, become familiar with the operation. Nothing is more embarrassing to an instructor than learning how to operate a piece of equipment during his/her presentation.

POWER CORD. Locate the power cord. Notice that it is concealed in the bottom of the device.

BULB. Be sure that you know how to change the bulb because bulbs frequently become inoperative at the most inopportune times. Follow these procedures in changing the bulb: Insure the projector is unplugged and be careful that the bulb is not hot. Wipe off areas of the bulb which were touched (removes skin oil that would boil and cause bulb to burst). (All these items mentioned in this study guide and workbook, regarding the use of equipment, will be demonstrated by your facilitator.)

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LOADING SLIDES INTO TRAY. Check the bottom plate of the slide tray to make sure it is in place, or you will drop your slides on the floor. Remove the ring on the top of the tray; then load slides into position desired and replace ring on top of tray.

JAMMED SLIDES. To release a jammed slide, insert and twist a coin on top of the screw in the middle of the slide tray, remove the slide tray, then remove the jammed slide. After you have accomplished the removal of the jammed slide, be sure to replace the ring on top of the tray; then turn the tray over and move the bottom plate until it is in place.

PROJECTOR HEIGHT. In adjusting the projector height, notice that the adjustment knob is located on the front of the projector. After you have made the proper adjustment, insure that the projector is properly focused for your slides. Notice that the focus adjustment knob is located on the top of the projector, unless you are using the remote control device.

PROJECTOR OPERATION. Using the remote control device, you will notice that there is a focus button in the middle of the control, and a forward and backward position to move slides forward or backward. Located near the receptacle for the remote control device is the on-off switch. Low beam is sufficient for most purposes; high beam will have to be used if you have rear-screen projection capabilities. Make sure that the switch is left in the fan position after use, to allow the projector to cool down. Notice that there is a selector button on the top side of the projector. This is used to move the tray or remove a slide from the projector.

Use of Slides

If you will follow these simple guidelines for using your slides, you will have a more meaningful presentation.

READING. Avoid reading from slides. Most people can read, so don't insult them by reading your slides.

SELECTION. Select slides which do not contain too much information. Slides that are too wordy or contain too much information tend to be distracting.

BLANK SLIDES. Use blank slides to separate areas covered, or at the beginning or end of a slide selection.

FLIP CHARTS

Flip charts are perhaps the most frequently used visual aid because of the ease of designing them.

Improper Use

The same kind of information that was presented for the chalkboard applies also to flip charts. (You may want to review this area for understanding.)

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LETTERING. Use of too small or too large letters constitutes improper use.

INFORMATION. Too little or too much information placed on each chart will be unproductive.

Use of Materials

The following are suggested methods for using materials in preparing your flip charts.

T-SQUARE. Use a T-square or ruler to provide straight guidelines for lettering.

MARKING PENS. (Any color except yellow) Grease pencils, food coloring (which can be removed with bleach if mistakes are made), or liquid shoe polish and cotton swabs can be used for lettering.

LETTER SIZE. When neatly printed, the following-size letters can be easily viewed from the indicated distances.

½ inch — 15 feet
1 inch — 30 feet
2 inches — 60 feet
3 inches — 100 feet

MOTION PICTURES

If you desire to use motion pictures, be sure to provide an introduction (with specific things for viewers to look for in the film) and a conclusion when using a film. When using a motion picture projector, the instructor should make sure that he/she knows how to operate the projector and that the film in the projector is ready to use when it is needed.

OVERHEAD PROJECTOR

Perhaps the quickest and easiest visual aid to use is the overhead projector transparency. If you will follow the steps discussed in this section, your use of this device will be quite effective.

Use of Projector

The following procedures will be helpful in using the overhead projector:

ON-OFF SWITCH. Locate the on-off switch (automatic timer for the fan is included) on the front of the device.

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BULB. To change the bulb, insure that the projector is unplugged, and that it is not hot. Wipe off areas of the bulb that may have been touched.

FOCUS. Notice that the focusing knob is a large knob on the stem of the device which is used for focusing the projector.

TEMPORARILY CUTTING OFF LIGHT. To temporarily cut off light, place a piece of cardboard over the projection lens (any kind of tape will suffice). CAUTION — *Do not* use the switch on the front of the machine as this lever is strictly for changing the lamps, should one become inoperative during your presentation.

Use of Materials (Transparencies, Etc.)

The following procedures will be most useful in preparing your transparencies.

KINDS OF MATERIALS. Materials, such as markers, grease pencils, Sharpies, etc., can be used. Special transparency sheets, and document protectors can be used as well.

FREE-HAND DRAWING. Free-hand drawings and lettering can be used, or lettering and cartoon kits can be placed behind the transparency sheet for tracing.

COLOR LIFTS. Color lifts can be made from magazine pictures. This process will be demonstrated during the formal class presentation.

TYPING. Material for transparencies can be typed, using a Gothic typewriter and sheets of typing paper, carbon paper, and transparency material.

SUMMARY

In this unit we took a look at Part I, instructor traits and techniques generally associated with educational presentations: directness, sincerity and enthusiasm, vocal qualities, physical qualities, use of gestures, use of notes and use of verbal support. We also discussed advantages and disadvantages of the lecture method of instruction. Advantages were: saves time, manpower, and supplements other methods of instruction. Disadvantages were: limited participation, difficulty of measuring student understanding, difficulty of maintaining interest, and difficulty of teaching skills. In Part II, the definition of a lesson plan was a guide for teaching, and the three purposes were: standardization of presentation, building of instructor confidence, and a logical and comprehensive development. There were four steps to lesson planning: determine the lesson objectives, conduct research, organize material, and select instructional aids. We discussed three major parts of a lesson plan: introduction, body, and conclusion.

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Part III was a discussion of requirements and research findings. We talked about objectives of the drug education program and objectives of the alcohol education program. Further, we covered counterproductive and productive messages for drug education classes. This portion also took a look at findings of the A. D. Little Study as well as educational implications of those findings. We talked more specifically of findings regarding drug education program methodology, effectiveness of drug education in the military, and study recommendations for improvement. Also discussed was the report to Congress by the Comptroller General of the United States. This section concerned itself with the major findings, conclusions, and recommendations of the GAO report on the drug/alcohol programs of the DOD. There were some disagreements between DOD and GAO regarding GAO's recommendations; however, GAO still contends that its results are valid.

Part IV was about visual aids. We discussed appropriate uses for the chalkboard, 35mm slides, flip charts, motion pictures, and overhead projector.

Remember, in order to have an appropriate, meaningful, and vigorous educational program, apply this information. It will be most beneficial to you as you seek to improve your drug/alcohol educational endeavors.

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APPENDIX

Following are answers to the exercises.

EXERCISE I

1. b 2. a 3. j 4. f 5. g 6. e 7. d 8. c
9. h 10. i

EXERCISE II

a. Identify three harmful effects of marijuana use.
b. Select four symptoms of barbiturate overdose.
c. Identify two causes of alcoholism.

EXERCISE III

1. i 2. e 3. c 4. g 5. h 6. a 7. b 8. d
9. f

EXERCISE IV

1. a 2. a 3. c 4. b 5. a 6. b 7. a 8. a
9. c 10. a 11. b 12. a

EXERCISE V

1. b 2. b 3. b 4. a 5. a 6. b 7. b 8. a
9. b 10. a 11. a 12. b 13. b 14. b 15. b
16. a

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EXERCISE VI

1. T 2. F 3. F 4. F 5. T 6. T 7. F 8. F

9. F 10. T 11. F 12. T

EXERCISE VII

1. T 2. F 3. T 4. T 5. F 6. F 7. T 8. F

9. F 10. T 11. F 12. F

EXERCISE VIII

1. Alcohol abuse is more prevalent among military personnel than drug abuse and it impairs the efficiency and effectiveness of military performance more than illegal drug use.

2. Drug abuse control program.

3. (1) DOD has not sufficiently recognized the severity of its alcohol problem; (2) DOD's approach to its drug problem is not effective as possible; and (3) DOD needs an information system to gage the size of its drug problem and alcohol problem and provide feedback on the effectiveness of its actions in correcting them.

4. Establish a DOD-wide information system.

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PLAN OF INSTRUCTION/LESSON PLAN PART I

NAME OF INSTRUCTOR	COURSE TITLE
	Drug and Alcohol Abuse Control
BLOCK NUMBER	**BLOCK TITLE**
V	Principles and Techniques of Drug/Alcohol Education

1 COURSE CONTENT	2 TIME
2. Guided Discussion Method a. Given an assigned segment of the Air Force Standardized Education Packages, satisfactorily personalize a guided discussion lesson plan from the package segment in accordance with the criteria listed on the Guided Discussion Method Performance Test Checklist. b. Given an approved drug/alcohol-related topic, satisfactorily prepare a 40-minute guided discussion-method lesson plan in accordance with the criteria listed on the Guided Discussion Method Performance Test. c. Given an evaluator-approved Guided Discussion lesson plan, satisfactorily prepare appropriate support materials for the lesson in accordance with the Guided Discussion Method Performance Test. d. Given an approved topic and lesson plan, satisfactorily present a 40-minute guided discussion method lesson to a live audience in accordance with the criteria listed on the Guided Discussion Method Performance Test.	

SUPERVISOR APPROVAL OF LESSON PLAN (PART II)

SIGNATURE AND DATE	SIGNATURE AND DATE

PLAN OF INSTRUCTION NUMBER	DATE	PAGE NO.
L3ALR73430B/L30LR7361B/L30ZR7364B	30 May 1978	47

ATC FORM OCT 78 133 PREVIOUS EDITION IS OBSOLETE

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SUPPORT MATERIALS AND GUIDANCE

Student Instructional Materials

Audio-Visual Aids
35mm Slides, Drug/Alcohol Education Models
Video Tape, Guided-Discussion Method

Training Methods
Lecture
Performance

Instructional Guidance
State that the primary method of Air Force drug and alcohol education programs is the guided discussion technique. Introduce the guided-discussion method of instruction, the advantages and limitations inherent in it, and the lesson plan requirements. Stress effective instructor delivery techniques when using this method of instruction. Emphasize questioning techniques in a guided discussion. Provide a list of topics for discussion from which the students can select their presentation subjects. Students will personalize a section of the AF Standardized Education packages as one Performance Test, emphasizing the formulation of good questions. Have students prepare their guided discussion lesson plans for review and evaluation prior to presentation. Use CCTV system to strengthen feedback on an availability basis.

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STUDY GUIDE AND WORKBOOK

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Technical Training

Drug and Alcohol Abuse Control

GUIDED DISCUSSION TECHNIQUES

April 1977

3250TH TECHNICAL TRAINING WING
3290th Technical Training Group
Lackland Air Force Base, Texas

Designed For ATC Course Use

DO NOT USE ON THE JOB

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Social Actions Training Branch
Lackland Air Force Base, Texas

SW 3ALR73430B/3OLR7361B/
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15 April 1977

GUIDED DISCUSSION TECHNIQUES

This unit of instructions is divided into two major parts. Part I covers the guided discussion method of instruction which is identified in AFM 50-62 as an effective setting to allow students to gain understanding of a subject by actively sharing their ideas, knowledge, and opinions. Part II covers questioning techniques. Effective questions are probably most valuable educational tools an instructor can use. The specific learning (criterion) objective(s) associated with each major section of this study guide and workbook (SW) will lead off applicable section.

GUIDED DISCUSSION METHOD OF INSTRUCTION

PART I

OBJECTIVE

Identify five advantages and three disadvantages of using a guided discussion method of instruction.

INTRODUCTION

The guided discussion method of instruction is receiving increasing emphasis as a means of presenting drug and alcohol abuse information. As stated in the Alcohol Awareness Seminar the minimum number of participants should be five. The maximum 20. The setting should be comfortable and discussion oriented. The major purpose of drug and alcohol education is to provide opportunities for attitude evaluation (and hopefully change). The guided discussion method of Instruction, in spite of certain disadvantages, is considered the best method to accomplish this purpose.

INFORMATION

ADVANTAGES/DISADVANTAGES

Advantages

PROMOTES PARTICIPATION. Because learning is often considered to be directly proportional to the degree of student participation, the more ways a student can participate in a lesson, the greater the chance that learning will occur. Students can participate in a guided discussion by mentally interpreting comments and questions from other students. They can also participate by mentally formulating and verbally presenting information.

STIMULATES EFFECTIVE THINKING. Effective thinking takes place because reflective thinking takes place. Students are presented with situations in which information provided by other students (questions, problems, statements, etc.) stimulates a mental response involving reflective thinking. This reflective thinking can then lead to new insights or learning on the part of each student.

PROMOTES GROUP SPIRIT. Students in a guided discussion often begin to feel that they are part of a team which is working toward achieving the lesson's objectives. By avoiding statements which may offend and anger students (thereby causing cooperation and participation to decrease), group spirit becomes an important factor in encouraging group and individual learning.

CORRECTS MISCONCEPTIONS. Situations arise in which students with various misconceptions come into contact with information from within themselves, other students, or the instructor. Because of this new information, students are allowed and often encouraged to alter their misconceptions.

ALLOWS EXPRESSION. Students are given an opportunity in which they can truely "share themselves." Guided discussion provides an opportunity for students to share their knowledge, experiences, attitudes, and ideas.

Disadvantages

TIME-CONSUMING. It takes much more time to cover information using a guided discussion than through the use of most other instruction methods.

This time factor is more effectively dealt with when effective questions are used such that the guided discussion is always aimed toward the lesson's objectives.

LIMITED BY CLASS SIZE. Discussions lose their effectiveness when fewer than eight or more than twenty people participate.

LIMITED TO CLASS KNOWLEDGE AND EXPERIENCE. If sufficient background is lacking in students to discuss a particular subject, the discussion can become a sharing of ignorance rather than knowledge. One way of dealing with this problem is to provide students with background information for discussion through the use of minilectures.

EXERCISE I

Complete the following exercise.

1. Name the five advantages of the guided discussion method of instruction?

2. What are the three disadvantages of the guided discussion method of instruction?

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OBJECTIVE

Identify characteristics of four instructor techniques which are effective when using the guided discussion method of instruction.

INTRODUCTION

Although many of the instructor techniques which apply to the lecture method of instruction also apply to the guided discussion method, additional techniques are needed.

The instructor conducting a guided discussion lesson must be a part of the discussion in order to insure participation, but must be sufficiently detached to insure the discussion is guided toward the completion of the objectives. Additional techniques are, therefore, required to perform both of these roles.

INFORMATION

INSTRUCTOR TECHNIQUES

Participation

CREATE A PERMISSIVE ATMOSPHERE

Encourage student participation (make students feel that their ideas are needed and wanted) and develop the idea that students are responsible for the discussion. Refrain from dominating the discussion or lecturing to the group.

Respect and encourage students to respect the idea that students' values concerning any area may differ.

Use Questions

TYPES OF QUESTIONS

Overhead Questions. This type of question is directed to all students and may be one of two types: lead-off questions which start the discussion or followup questions (used to consider an idea more deeply or develop an area more thoroughly) which guide the discussion.

Direct Questions. These questions are directed to specific students in order to bring silent or inattentive students into the discussion.

They may also be used to encourage participation from students with particular points of view.

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QUALITIES OF QUESTIONS. How, what, and why questions stimulate discussion while yes/no, oversized, one word answer and leading questions tend to hinder discussion. (Review questions to avoid in study guide 3ALR73430B—II-(3)-5/3OLR7361B.)

TECHNIQUES OF QUESTIONING. When asking questions, allow enough time for students to respond. If there is some confusion regarding a particular question, repeat the question or provide additional clarification.

Interim Summaries

Use interim summaries between major teaching areas (criterion objectives). Interim summaries should be used to review information covered (using a logical sequence) while mentioning individual students' contributions. All information presented in an interim summary should be clearly tied to the major idea of the teaching area.

Interim summaries are useful when a digression from the discussion occurs. By summarizing ideas presented and then asking an appropriate question, the discussion will again head in the right direction.

Whenever a "dead-lock" situation arises between students, an interim summary can be used to summarize ideas presented, and thereby lead to acceptance, agreement, or compromise.

Interim summaries can also be used whenever needed to aid in transitioning from idea to idea or contribution to contribution, etc.

Positive Discussion Direction

Allow students to develop areas of discussion as long as they seem profitable and are related to the objective of the lesson. Intervene when necessary after, rather than during, a student's contribution.

When side discussions begin between students, ask then in a positive manner to give the group the benefit of their information.

A student's contribution that deals with a topic to be covered later can be effectively dealt with by mentioning the value of the student's contribution and by mentioning that the topic will be covered later.

Encourage clarification of contributions that contain terms that might be unfamiliar to others or ideas that seem complex and difficult to understand.

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EXERCISE II

Complete the following exercise.

Which of the following statements concerning guided discussion instructor techniques are:

T True
F False

____1. Students participating in a discussion should be informed that the responsibility for discussion belongs to the instructor.

____2. Overhead questions are useful in obtaining responses from particular students.

____3. Questions which stimulate discussion usually begin with the words how, what, why, etc.

____4. If students fail to respond to a particular question you have used, go on to your next prepared question.

____5. Interim summaries are only useful between criterion objectives.

____6. If a particular student's contribution contains words that might not be familiar to the other students, encourage that student to provide additional clarification.

____7. Students should be allowed to continue a discussion in areas which are unrelated to the lesson's objectives.

____8. Whenever a "deadlock" situation occurs between two students, they should be encouraged to continue their discussion until one student "gives in" to the other.

____9. Discussion can be stimulated when an instructor is asked a question by reversing or relaying it.

____10. In order to insure that students have accurate information, the instructor should lecture to students as much as possible.

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OBJECTIVE

Identify the three major parts of a guided discussion lesson plan and a brief description of the contents of each part.

INTRODUCTION

Although a lecture and guided discussion lesson plan follow the same basic format, there are a number of specific differences. The three major parts of the guided discussion lesson plan are the introduction, body, and conclusion.

INFORMATION

GUIDED DISCUSSION LESSON PLAN

INTRODUCTION

ATTENTION STEP. This step is designed to gain the attention of students and focus it on the subject for discussion.

MOTIVATION STEP. Not only is this step used to provide students with realistic benefits concerning the discussion, it is also used to encourage students to participate and respect the statements of others within the discussion.

OVERVIEW STEP. This step is used to clearly explain the sequence of areas to be covered in the discussion and the interrelationship between these areas.

TRANSITION STEP. The transition step is used to tie information described in introduction with the first question to be used in the body (discussion).

Body

LEFT HAND COLUMN. The left hand column in a guided discussion lesson plan is identical to a lecture lesson plan in that the material to be taught (discussed) is stated. This is done through the use of criteria objectives and teaching steps (evaluation questions are not needed).

RIGHT HAND COLUMN. The right hand column contains not only personalization, but also those questions to be used in guiding the discussion. One lead off question should be used for each criterion objective and at least one followup question for each teaching step. The idea is to have enough questions to achieve the objectives and teaching steps stated in the left-hand column. Interim summaries and transitions between criterion objectives should also be included in this section.

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Conclusion

SUMMARY STEP. Review the main ideas covered in the lesson and relate them to the overall objectives of the lesson. (A reverse order of review should be used i.e., last objectives to the first). In reviewing main ideas covered, individual student contributions should be mentioned.

REMOTIVATION STEP. Once again, realistic benefits of the lesson should be provided.

CLOSURE STEP. Provide an appropriate definite closure to the discussion through the use of one or two sentences.

EXERCISE III

Match each of the following parts of a guided discussion lesson plan with its appropriate description.

INTRODUCTION	BODY	CONCLUSION
a. Attention	e. Left-hand column	g. Summary
b. Motivation	f. Right-hand column	h. Remotivation
c. Overview		i. Closure
d. Transition		

1.____ Information that is required to be taught (criterion objectives, teaching steps).

2.____ Information on areas to be discussed and the way these areas are interrelated.

3.____ Statement that provides an appropriate, definite ending.

4.____ Realistic benefits of the discussion; why students should remember what was discussed.

5.____ Sentence(s) used to tie two major lesson plan parts together.

6. ____Leadoff and followup questions used to achieve lesson objectives.

7.____ Statement that gains student interest and relates it to the content of the lesson.

8.____ Realistic benefits of the discussion; why students should listen to and participate in the discussion.

9.____ Review of ideas discussed and their relation to the overall purpose of the lesson (students' contributions are utilized).

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QUESTIONING TECHNIQUES

PART II

OBJECTIVE

Identify five purposes of using questions.

INTRODUCTION

Effective questions are probably one of the most valuable educational tools an instructor can use. As indicated in the ATC Technical Instructor Course Study Guide:

> Good questions are essential for proper communication between instructor and student. Too often an instructor, because he lacks the skill to question effectively, uses one-way communication with little or no student participation. The normal reaction of a student caught in this situation will be boredom and a disinterest in the subject matter. Learning must be a two-way street. There should be a substantial amount of time during the learning situation created by the instructor when the student is actively participating in the learning process. A meaningful learning activity can be effectively initiated and controlled through the use of questions.

The information you receive concerning questioning techniques will be extremely valuable to you not only here at this school, but also back at your home base. With minor modifications, the same questioning techniques apply to lecture method and guided discussion method presentations, counseling situations, and small group activities.

INFORMATION

PURPOSES OF QUESTIONS

Five Primary Purposes Or Reasons For Using Questions

GAINING AND MAINTAINING INTEREST. Students become more interested in a lesson when questions are used because they are actively participating in it. Students are able to respond to questions or participate in two ways. First, by mentally formulating answers to questions and second, by verbally responding to questions with the answers they have formulated.

In a lecture presentation questions can be used to guide student thinking by calling areas of information which support the lesson's objective to the attention of each student.

DETERMINING ATTITUDES. Questions provide opportunities for dealing with students' attitudes. When questions are used in a lesson (especially in a guided discussion) students respond with information that reveals their attitude. By revealing their attitude, students

are then able to compare their attitudes with those of other students. The instructor is then given an opportunity in which he/she can influence students' attitudes such that growth may occur.

OBTAINING INFORMATION. Information supplied by students when answering questions provides verbal support for lesson objectives. By sharing their ideas, examples, experiences, etc. useful information is obtained.

SUMMARIZING AND EVALUATING INFORMATION. When questions are used to summarize and evaluate information in a lesson, both the students and instructor become involved. Summaries with questions contain student as well as instructor information and this leads to greater student attention toward the summary.

EVALUATION QUESTIONS. When questions are used for evaluation purposes, students are able to assess their progress while the instructor is able to determine how well his/her objectives have been met.

OBJECTIVE

Identify the characteristics of memory and thought provoking questions and examples of each.

INTRODUCTION

In order to effectively use questions and to achieve your purpose for using them, it becomes important to select the most appropriate type of question.

INFORMATION

CHARACTERISTICS OF MEMORY AND THOUGHT-PROVOKING QUESTIONS

There are two basic categories of questions, memory questions and thought-provoking questions.

Memory Questions

An instructor uses memory questions whenever recall of specific information is desired. Understanding of the information recalled is not a factor, only the fact that the information is recalled. An answer to a memory question usually consists of short, often one-word answers. An example of a memory question and answer would be:

Question: How many progressive stages of alcoholism are there?

Answer: Five

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Because memory questions obtain specific information, they are useful in emphasizing facts, or summarizing main points within a lesson. Types of questions which fall within this category are:

a. Selective recall
b. Statement of relationships
c. Illustration or example

Thought-Provoking Questions

Unlike memory questions, thought-provoking questions require a great deal of student knowledge and understanding i.e., a great deal of student thought. In answering a thought-provoking question, students become involved in such mental activities as judging, analyzing, organizing, and comparing, etc. These questions require students to do more than merely recall memorized information. Thought-provoking questions can be any one of the following types:

a. Comparison
b. Decision for or against
c. Cause and effect
d. Explanation
e. Case problem

Thought-provoking questions are useful in any educational situation, but especially in those situations where a discussion of information is desired.

EXERCISE IV

The following exercise is designed for individual review and self-evaluation purposes.

Identify each of the following questions as a

a. memory question
b. thought-provoking question

_____1. What are the three major parts of a lesson plan?

_____2. How do each of three major parts of a lesson plan differ?

_____3. Why would a thought-provoking question be more useful in a guided discussion than a memory question?

_____4. What are the five purposes of using questions?

_____5. Why should questions be used in any educational presentation?

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OBJECTIVE

Identify seven types of questions to avoid.

INTRODUCTION

Questions which fail to promote discussion or tend to create negative feelings on the part of students should be avoided in any educational situations. Questions with these characteristics will also fail to achieve your purpose for using questions. Before using any question, check to make sure it is not one of the following types of questions.

INFORMATION

Leading Questions

Leading questions are questions which suggest the answer. Students aren't required to think, all they have to do is agree with the instructor. Example: You always use effective questions in your lessons, don't you?

Catch Questions

Catch questions are those questions which tend to trick or trap students. Example: Which of the following steps found in the introduction of a lesson plan is the most important: attention step, motivation step, summary step?

Irrelevant Questions

Those questions which are not pertinent to the objectives of a lesson or those questions which are based on obscure, elementary, or unimportant details are irrelevant questions. Example: On what page of AFM 50-62 *"Principles and Techniques of Instruction"* can the table of contents be found?

Pumping Questions

Whenever a student is asked a battery or series of questions, which he/she is unable or unwilling to answer, the instructor is using pumping questions. Example: Pumping questions are those types of questions which are often used by an attorney to gain information from a witness. Actually, pumping questions are not really a particular type of question, they are a way of asking a series of any type of questions.

Oversized Questions

Oversized questions are questions which are not limited to one idea or questions which cover so much information that they would be impossible to answer within a reasonable period of time. Often, an oversized question can be broken down into a number of smaller questions. Example: What are the purposes of an attention step, motivation step, and overview step within a lesson plan?

Ambiguous Questions

Those questions which seem unclear, indefinite, or have more than one possible meaning are referred to as ambiguous questions. Example: What about questioning techniques?

Yes Or No Questions

These are questions which greatly limit discussion because they can be answered with a "yes" or "no." If an occasion ever arises where a yes or no question is needed, it should be followed by a "how" or "why" statement in order to promote discussion. Example: Do you know how to prepare a lesson plan?

EXERCISE V

The following exercise is designed for individual review and self-evaluation purposes.

Rewrite each of the following questions so that they no longer are "questions to avoid."

1. There are five purposes of using questions, aren't there?

2. Why is the material in the left-hand column of a lesson plan required for personalization?

3. On what page of this study guide can the definition of a lesson plan be found?

4. How would you define pumping and oversized questions?

5. What about the advantages of the lecture method of instruction?

6. What are the disadvantages of the lecture method of instruction?

OBJECTIVE

Identify the considerations involved in preparing, asking, and answering questions in an educational setting.

INTRODUCTION

Knowing which types of questions are effective does not insure that questions are used effectively. When considering effective use of questions, three categories of techniques need to be considered: preparing questions, asking questions, and answering questions.

CONSIDERATIONS IN USING QUESTIONS

INFORMATION

Preparing Questions

PLAN QUESTIONS IN ADVANCE. The majority of questions used in any lesson should be planned in advance. Although spontaneous questions are needed at times, by preparing questions in advance, you will avoid the possibility of questions being hastily thought out or poorly worded.

RELATE QUESTIONS TO OBJECTIVES. When preparing questions, insure that they are related to subject areas defined by your lesson objectives. In this way, your questions will be more useful in achieving your objectives. One good way to check your questions is to answer them yourself and then see how well they fit in with your objectives.

CREATE MEANINGFUL QUESTIONS. In order to create effective, meaningful questions, the purpose of each question should be considered. Considering the purpose of each question will help you select the most appropriate category and type of question to use.

EXPERIENCE LEVEL. In order for questions to be meaningful, the ability and experience levels of students who will be answering the questions should be considered. If your questions are too difficult or too easy, they will be ineffective.

IMAGINATIVE. Finally, meaningful questions are original and interesting. If your questions are prepared in an unimaginative way, more than likely, the answers you receive from the use of your questions will also be unimaginative.

Asking Questions

TONE OF VOICE. Ask questions in a clear natural tone of voice. Whenever questions are asked, they should be asked in a clear, natural, conversational style. In this way, the flow of the lesson is not disrupted.

PHRASING. Phrase questions according to the type of response desired. There are three responses that an instructor might want from his/her students. These responses can be determined by the way questions are phrased.

TYPE OF QUESTIONS. There are three types of questions you may find, useful in the guided discussion.

Rhetorical Question (No Response). This type of question is directed to all students although no response is desired. A rhetorical question is used primarily at the beginning of a lesson or subject area within a lesson. It is used whenever an instructor wants his/her students to think about a particular idea or subject area. Example: How many of you have ever thought about why instructors use lesson plans?

Overhead Question (Response From Any Student). This type of question is directed to all students with the purpose of obtaining a response from any student. The majority of questions used in a lecture or guided discussion are phrased in an overhead manner i.e., are overhead questions. In a guided discussion, these questions may be used to start (leadoff) a discussion or to develop (followup) an area of discussion. Example: Why do instructors use lesson plans?

Direct Question (Response From A Particular Student). A direct question is directed to the entire class (in order to maintain interest of all students) and then directed to one particular individual. Direct questions are useful in getting silent or inattentive students to respond or in getting students with particular points of view to respond. (e.g., responses from two students with opposite points of view will stimulate discussion.) Example: Why do instructors use lesson plans, Sgt. Jones?

DISTRIBUTE QUESTIONS AT RANDOM. Avoid using a set pattern when asking students questions e.g., front-to-back, left-to-right, etc. By using a pattern, students will soon learn the pattern and become attentive only when their turn is approaching. Also important, is the idea of distributing questions evenly. By replying on a few students to provide all of the answers, other students will begin to think that their contributions are not worthwhile.

RESPONSE TIME. Allow a reasonable amount of time for response. Realize that students need time to develop answers to questions. If after a reasonable period of time no student response is given to a question, restate the question or provide additional clarification.

Answering Questions

AVOID TOO MANY DIRECT ANSWERS. An instructor can provide direct answers to student's questions. This should not be done excessively in discussion situations as it tends to have a negative effect on student discussion.

AVOID INSTRUCTOR OPINION. When providing a direct answer to a question in which an opinion is desired, an instructor should avoid stating his/her point of view. In this way, an instructor objectivity is not lost due to students agreeing or disagreeing with the instructor's point of view.

REVERSE QUESTIONS. Reversing a question back to the student who asked it should be done whenever it is felt that the student is capable of answering it. In this way, greater reflective thought on the part of the student will take place. Example:

Student to Instructor: Why do instructors use questions?

Instructor to Student: Why do *you* think instructors use questions?

RELAY QUESTIONS. Redirecting or relaying a question asked by one student to another student for answering is a useful instructorial skill. In this way, participation can be obtained from a student who has rarely participated or a student with a particular point of view.

EXERCISE VI

1. Why is it important to plan questions in advance?

2. When is a rhetorical question most often used?

3. What should an instructor do to insure that is questions or not asked in a set pattern?

4. What is the main point of instructors not answering to many questions directed at him/her?

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EXERCISE ANSWERS

EXERCISE I

1. Advantages

   a. Promotes Participation.
   b. Stimulates Effective Thinking.
   c. Corrects Misconceptions.
   d. Allows Expression.

2. Disadvantages

   a. Time-Consuming.
   b. Limited by class size.

EXERCISE II

1.	F	6.	T
2.	T	7.	F
3.	T	8.	F
4.	F	9.	T
5.	F	10.	F

EXERCISE III

1.	E	6.	F
2.	C	7.	A
3.	I	8.	B
4.	H	9.	G
5.	D		

EXERCISE IV

1. A
2. B
3. B
4. A
5. B

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EXERCISE ANSWERS — CONTINUED

EXERCISE V

Better ways of rewriting the questions are as follows:

1. What are five purposes of using questions?

2. Compare the information contained in the left-hand column to that of the right-hand column of a lesson plan?

3. What page of this study guide contains the definition of a lesson plan?

4. a. What is the definition of a pumping question?

b. Define "Oversized Question?"

5. Explain two advantages of the lecture method of instruction?

6. Explain three disadvantages of the lecture method of instructions.

EXERCISE VI

1. Planning questions in advance will avoid the possibility of questions being hastily thought out or poorly worded.

2. Primarily at the beginning of a lesson or subject area where no response is desired.

3. Ask questions of the group at random.

4. Not answering questions directly helps maintain the instructor's objectivity and encourages other students to think and answer the questions themselves.

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STUDY GUIDE WORKBOOK

3ALR73430B/30LR7361B/30ZR7364B-V-2-2

Technical Training

Drug and Alcohol Abuse Control

Principles and Techniques of Drug/Alcohol Education

GUIDED DISCUSSION METHOD PRACTICUM

1 August 1978

Headquarters 3250 Technical Training Wing (ATC)
(USAF Technical Training School)
Lackland Air Force Base, Texas 78236

DESIGNED FOR ATC COURSE USE. DO NOT USE ON THE JOB.

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ATC FORM 214 (JAN 76) OBSOLETES ATC FORMS 214, MAY 68, 522, NOV 63 AND 523, MAY 71. STANDARD COVERSHEET

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SW 3ALR73430B

Social Actions Training Branch
Lackland Air Force Base, Texas 78236

30LR7361B/30ZR7364B-V-2-2
1 August 1978

Principles and Techniques of Drug/Alcohol Education

GUIDED DISCUSSION METHOD PRACTICUM

OBJECTIVES

The objectives for this practicum include satisfactorily developing a guided discussion lesson plan and conducting a guided discussion in accordance with the Guided Discussion Progress Checklist.

INTRODUCTION

The purpose of the guided discussion practicum is to help you develop or improve your guided discussion teaching skills. This is accomplished by having you plan for and teach two one-hour guided discussions. Although both lesson plans and discussions will be graded according to the Guided Discussion Progress Checklist (Attachment 2), the first lesson plan and discussion are for practice, while the second plan and discussion are for evaluation.

INFORMATION

GENERAL GUIDELINES

Requirements

At the appointed time, before your practice and evaluation discussions:

TOPIC SELECTION. You will be able to choose two topics; one for practice, and one for evaluation.

Practice Topic Guidelines. Select a topic for your practice session from the topics contained in Attachment 4. These topics come from the Air Force Standardized Substance Abuse Education Packages which you have been given. You may choose either a developed or undeveloped topic for your practice session, but it must be a different one from other students in your group.

Evaluation Topic Guidelines. You may choose either an undeveloped topic from Attachment 4 or a drug/alcohol-related topic of your own choosing so long as it meets the following criteria: a different topic area than your practice session (drugs vs alcohol), appropriate to the time limits, based on a reference contained in the Social Actions Training or Wilford Hall Library, and does not duplicate the topic of another student.

Supersedes HO IV-4-10, 1 July 1977.

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LESSON PLAN GRADING. Turn in your lesson plans at the appointed time for grading. Remember, your lesson plan should not duplicate that of another student. The ones selected from Attachment 4 should contain all the pages of the standardized education packages indicated, but no more than indicated.

DUPLICATE COPY. Once your lesson plan is graded, make a copy of the corrected lesson plan to enable your instructor to keep one while you conduct your guided discussion.

VIZ AIDS. Do not forget to design adequate vizual aids to assist your group in staying on topic. The overhead projector is particularly easy to operate while remaining seated during guided discussions.

Procedures

Practice and Evaluation Session Selected Discussion Topics list is appended hereto Attachment 4. Practice and evaluation discussions will be conducted in a small group other than your own. They will, however, be graded by the same instructor who graded your lecture-method practicum.

TIME. Discussions will last forty minutes, with the remaining ten minutes being used for student feedback and instructor grading information.

MEETING SUSPENSES. If, for any reason, you will be unable to submit a lesson plan of conduct a guided discussion at the appointed time, inform your grading instructor. Failure to present a lesson plan or guided discussion without a prior acceptable excuse is considered an academic failure.

COORDINATING AUDIO-VISUAL EQUIPMENT. If you desire to use any audio-visual equipment for your guided discussion, make prior arrangements with your grading instructor.

GRADING CRITERIA. Review the attached grading criteria (Atch 3) and progress checklist (Atch 2) to insure you are thoroughly familiar with the criteria against which you will be graded. This review will assist you in preparation for your guided discussion.

REMAKES. If you should not meet the grading criteria satisfactorily you normally will be given another chance to improve. Remakes of the guided discussion will be conducted on a <u>new topic</u>, and you are normally given three days to prepare a new one. Your instructor is available to help you at any time with understanding the principles of the guided discussion method.

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SAMPLE LESSON PLAN

The following lesson plan segment was adopted from a lesson plan prepared by 1Lt Donald Dapcwich, a former student in this course. The information for this lesson plan was developed from Section 6a, page 32, of the Drug/Alcohol Awareness Seminar for Commanders/Supervisors/First Sergeants.

TOPIC. Discuss the process of documentation by commanders, supervisors, and first sergeants as an important means of dealing with a subordinate's suspected alcohol abuse problem.

OBJECTIVE. Describe five documentation steps to use when dealing with a suspected alcohol abuse problem.

INTRODUCTION

ATTENTION

Imagine having someone work for you, a friend, whose work hasn't been as good as it once was. You've been thinking that an alcohol problem might be involved, but you just aren't sure. You'd like to talk to the individual, because you're concerned, because its having an impact on your job; but, you just don't have anything definite. You just don't know what to say.

OVERVIEW

Today, we will be discussing one effective way of dealing with this type situation: documentation. We will be taking a complete look at each of the five steps involved in the process of documentation.

MOTIVATION

Documentation is beneficial, since it can help both you and the individual about whom you are concerned, by enabling you, at the most appropriate time, to have the most effective thing to say. Our discussion on documentation can be the most beneficial with the sharing of your thoughts and information about your relevant supervisory experiences. If there are differences of opinion, I would encourage you to respect the rights of others to have their opinions. In this way, we're more likely to have a better sharing of ideas and therefore a more rewarding discussion.

ATTACHMENT 1

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TRANSITION

Documentation is a step-by-step process, and we first need to look at the step which provides a framework for documentation.

BODY

PRESENTATION

CRITERION OBJECTIVE 1: Describe five documentation steps to use when dealing with a suspected alcohol abuse problem.	Why should you bother with documenting a subordinate's suspected alcohol abuse problem?
	What steps should you take?
Define unacceptable behavior/ performance.	Why should you set standards of acceptable or unacceptable behavior and performance?
	How can you accomplish this?
	What types of unacceptable behavior and performance might be displayed by an individual?
a. Substandard duty performance.	How might duty performance appear substandard?
	How might an individual justify duty performance problems?
b. Military law problems.	What types of problems might be encountered with military law?
	How might an individual react as a result of these problems?
c. Civil law problems.	What types of problems with civil law might occur?

NOTE: Continue in this manner for each of the areas in this objective.

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SUMMARY

In today's discussion, we've taken a complete look at each of the steps involved in the process of documentation. (Mention student contributions when reviewing each of the major teaching steps covered.)

a. Define unacceptable behavior/performance.

b. Observe behavior/performance.

c. Document unacceptable behavior/performance.

d. Build case file.

e. Seek consultation.

REMOTIVATION

Dealing with the suspected alcohol abuse problem of a subordinate, a friend, can be an uncomfortable situation. Documentation is an effective means of dealing with this situation, since it enables you to have the most appropriate thing to say at the most opportune time.

CLOSURE

Documentation -- it can help the individual about whom you are concerned, and it can help you.

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GUIDED DISCUSSION METHOD PRACTICUM CHECKLIST

STUDENT NAME _____ DATE _____

INSTRUCTOR _____ GROUP _____

☐ Practice ☐ Evaluation ☐ Remake

PREPARATION	S	NI	U	COMMENTS
1. Objectives				
a. Appropriate number				
b. Behavior to be learned specified				
c. Appropriate subject				
2. Lesson organized in logical sequence				
3. Content sufficient to meet objectives				

Satisfactory Lesson Plan — Preparation

All areas must be graded satisfactory — Grade S NI U

PRESENTATION

Satisfactory 100-70 pts
Unsatisfactory 69- 0 pts

Needs Improvement 69-60 pts
(Practice Only)

Presentation

Presentation
Total Points _____

Grade S (NI) U

Student Acknowledgement _____

***Automatic Presentation Failure
2. Objectives met - three or more teaching steps not presented or developed as planned
4a. Lesson Timing - Lesson duration less than 28 min. or more than 52 min.

1112

Designed for ATT... Use
Do not write on this sub...

ATTACHMENT 2

1690

GUIDED DISCUSSION PROGRESS CHECKLIST

	S	NI	U	COMMENTS
PRESENTATION				
1. Introduction				
a. Attention gained	1	0	0	
b. Motivation	4	0	0	
c. Overview	2	0	0	1.__
2. Objectives Met ***	15	3	0	2.__
3. Clarity of Presentation				
a. Verbal support	1	0	0	
b. Transition	4	0	0	
c. Interim summary	4	0	0	
d. Visual-aids	3	0	0	3.__
4. Pacing the Lesson				
a. Lesson timing ***	4	0	0	
b. Internal timing	4	0	0	
c. Progression by student needs	2	0	0	4.__
5. Instructor Qualities				
a. Physical qualities	1	0	0	
b. Vocal qualities	2	0	0	
c. Instructor attitude	6	1	0	5.__
6. Questioning Techniques				
a. Types of questions	10	2	0	
b. Elicits student participation and attention	10	2	0	
c. Guided and controlled	10	2	0	6.__
7. Provides Opportunity for Discussion	10	2	0	7.__
8. Conclusion				
a. Summary	4	0	0	
b. Remotivation	2	0	0	
c. Closure	1	0	0	8.__

Presentation Total Points ___ 1113

1691

GUIDED DISCUSSION PRACTICUM

EVALUATION CRITERIA

PREPARATION OF LESSON

1. Objectives.

a. Appropriate Number

Appropriate number of objectives to develop lesson topic	Inappropriate number of objectives (too many, or too few)	No objectives provided
S	NI	U

b. Behavior to be Learned Specified

Both amount and area to be covered are specified	Either amount or area to be covered is not specified	Both amount and area to be covered are not specified
S	NI	U

c. Appropriate Subject

Objective(s) stated is/are related to the approved area	Majority of objectives stated are related to the approved area	Objective(s) stated is/are not related to the approved area
S	NI	U

2. Lesson Organized in Logical Sequence.

Lesson flows; teaching steps appropriately placed to develop lesson objectives; objectives and teaching steps are logically sequenced	Majority of teaching steps and/or objectives appropriately placed and logically sequenced	Inappropriate placement and illogical sequence of majority of teaching steps and/or objectives; lesson is confusing
S	NI	U

3. Content Sufficient to Meet Objectives.

Adequate number of teaching steps, information and questions to fully develop objectives	Additional teaching steps, information, questions needed or need to remove excess material	Little or no attempt to develop objectives
S	NI	U

ATTACHMENT 3

1692

PRESENTATION

1. Introduction.

a. Attention Gained

Stimulating; creative; relates directly to subject	Difficulty in gaining attention of students and/or focusing on subject matter due to content and/or method of presentation	Little or no attempt to gain attention; content inappropriate and/or unrelated to subject matter; ineffective method of presentation
S	NI	U

b. Motivation

Stimulating; clearly related, realistic benefits of lesson to students	Attempted to provide students with information on realistic benefits of lesson; less than effective due to method of presentation	Lacking or inappropriate content; little or no attempt to provide information on lesson benefits; method of presentation was ineffective
S	NI	U

c. Overview

Clearly explained sequence of areas to be covered	Somewhat disorganized; difficult to determine sequence of areas to be covered	Little or no attempt to provide information on sequence of areas to be covered
S	NI	U

2. Objectives Met.

Objectives met; information in each teaching step presented and developed as planned	Objectives not met; one or more teaching steps not presented or developed as planned	Objectives not met; two or more teaching steps not presented or developed as planned
S	NI	U

3. Clarity of Presentation.

a. Verbal Support (Definitions, quotes, examples, etc.)

Clarified, simplified ideas; added variety; gave emphasis to key points	Less than effective use; inappropriate length of time, context, content	Needed but lacking
S	NI	U

1115

b. Transition

Provided smooth relationship between parts of the lesson, criterion objectives, teaching steps, points of discussion, students contributions; aided flow of material	Vague, abrupt relationship between points; occasionally vague, abrupt; needed in additional parts of the lesson	Lacking or needed in many additional parts of the lesson
S	NI	U

c. Interim Summary

Used at the end of each criterion objective (except the last) and also when needed for lesson guidance; reviewed main points covered in logical sequence using student's contributions; clearly related information to criterion objective(s)	Used less often than at the end of each CO (except the last) and when needed for lesson guidance; reviewed majority of main points covered; disorderly sequence used; few student contributions mentioned; information not clearly related to CO(s)	Failed to provide interim summaries
S	NI	U

d. Visual Aids

Well-prepared and effectively used; aided in information clarification	Needed to provide support to minor areas of emphasis; less than effective techniques of use and preparation	Needed to provide support t major areas of emphasis; preparation and techniques of use greatly detracted from lesson effectiveness
S	NI	U

4. Pacing the Lesson.

a. Lesson Timing

40 minute lesson 36 - 44 min.	40 minute lesson 32-48 min.	40 minute lesson 28-52 min.
S	NI	U

b. Internal Timing

Ideal distribution of time between lesson elements; areas covered as planned; (mini-lecture if used did not exceed 8 minutes)	Imbalance in time distribution; certain areas received too little or too much time (Mini-lecture if used did not exceed 9 minutes)	Extreme imbalance in time distribution; (mini-lecture exceeded 9 minutes)
S	NI	U

1694

c. Progression by Student Needs

Appropriate time given to respond to students' spontaneous questions and statements; demonstrated concern for student learning	Additional time needed to respond to students' spontaneous questions and statements	No response given to students' spontaneous questions or statements; demonstrated lack of concern for student learning
S	NI	U

5. Instructor Qualities

a. Physical Qualities

(1) Gestures

Natural, well-timed, spontaneous, definite; aided the communication process	Gestures used lacked effectiveness due to awkwardness, timing, etc.	Quality and/or amount of gestures was distracting; detracted from the communication process
S	NI	U

(2) Eye Contact

Eye contact with students maintained throughout lesson	Eye contact with students occasionally lost	Minimal or no eye contact with students due to focusing of attention on notes, physical surroundings or particular group of students
S	NI	U

(3) Physical Mannerisms

Purposeful, moved with ease; aided transitioning between points	Awkward; lacked purpose and ease	Distracting due to type and/or amount
S	NI	U

(4) Posture

Appropriate posture, created favorable, professional impression throughout lesson	Occasional periods where posture was inappropriate	Inappropriate posture throughout majority of lesson; distracting; failed to create favorable professional impression
S	NI	U

1117

(5) Poise/Dress

Appearance created favorable impression; added to lesson effectiveness	Appearance created less than favorable impression	Appearance created unfavorable impression; detracted from lesson effectiveness
S	NI	U

b. Vocal Qualities

(1) Vocal Variety

Vocal qualities added to lesson effectiveness; force, rate, pitch, clarity in tune with meaning, emotional content emphasis	Vocal qualities occasionally detracted from lesson effectiveness	Vocal qualities detracted from lesson effectiveness; lack of or excessive variation in force, rate, pitch, clarity throughout majority of lesson
S	NI	U

(2) Verbal Mannerisms

Absence of distracting verbal mannerisms such as uh, uhm, etc.	Occasional use of distracting verbal mannerisms	Use of distracting verbal mannerisms throughout majority of lesson
S	NI	U

c. Instructor Attitude

(1) Enthusiasm

Highly motivated, demonstrated interest and involvement through adjustments in vocal rate, pitch, gestures, body movement, etc.	Appeared motivated throughout majority of lesson	Demonstrated lack of interes and involvement
S	NI	U

(2) Sincerity

Demonstrated acceptance, presented and discussed belief in information; adjustments in vocal rate, pitch, gestures, body movement adjusted to content of lesson	Demonstrated acceptance, belief in information throughout majority of lesson	No attempt to demonstrate acceptance, belief in information through verbal, physical expression
S	NI	U

1696

(3) Confidence

S	NI	U
Vocal qualities, physical qualities in tune with content and mood of lesson; lesson plan used as a guide and not as a crutch	Vocal qualities (occasional use of verbal distractions, etc.) Physical qualities (distracting, body movements, gestures, etc.) reliance on lesson plan detracted occasionally from lesson effectiveness	Vocal qualities (frequent use of verbal distractions, etc.), physical qualities (excessive or lack of body movement, etc.), excessive reliance on lesson plan, greatly detracted from lesson effectiveness

---

6. Questioning Techniques.

a. Types of Questions

S	NI	U
Types of questions asked (i.e. overhead, direct) and the method of asking them added to lesson effectiveness	Types of questions asked and the method of asking them occasionally detracted from lesson effectiveness.	Types of questions asked and the method of asking them greatly detracted from lesson effectiveness

b. Elicits Student Participation and Attention

S	NI	U
Stressed student responsibility for discussion in motivation step of introduction to lesson; questions utilized such that every student participated more than once	Statements regarding student responsibility for discussion were unclear; questions utilized such that each student participated in the discussion at least once	No mention of student responsibility for discussion; not all students participated in the discussion

c. Guided and Controlled

S	NI	U
Kept discussion guided toward objectives; effective use of questions, interim summaries, etc.; encouraged clarification and depth when needed	Kept discussion guided toward objectives majority of time; discussion rarely strayed from stated objectives; occasionally seemed as though students were controlling discussion; encouraged clarification and depth when needed majority of the time	Discussion frequently strayed from stated objectives; frequently seemed as though students were controlling discussion; rarely encouraged clarification and depth

1119

7. Provides Opportunity for Discussion.

In motivation step of introduction of lesson, clearly encourage students to respect statements of others; refrained from dominating the discussion or lecturing to the group (except during mini-lecture, if used); refrained from inappropriately interrupting students; was not critical of differing statements	Encouragement to respect statements of others was not clear; ocassionally dominated the discussion and/or lectured to the group; rarely, inappropriately interested students; was rarely critical of differing statements	No mention of respect for other's statements; frequently dominated the discussion and/or lectured to the group; often inappropriately interrupted students; was critical of differing statements
S	NI	U

8. Conclusion.

a. Summary

Restated main ideas using students' comments; related main ideas to criterion objectives; reviewed criterion objectives in sequence of last to first	Reviewed, restated majority of main ideas in orderly sequence; unclear relationship between ideas and criterion objective(s); few students' comments used	Vague, incomplete review of main ideas; no orderly sequence used; failed to establish relationship of ideas with criterion objectives; failed to use students' comments
S	NI	U

b. Remotivation

Stimulating; capitalized on realistic potential uses of information presented	Information presented on uses of lecture material lacked realism, meaningful applicability	Little or no attempt to tell students how to use information
S	NI	U

c. Closure

Provided appropriate, definite closure to lesson	Indefinite and/or abrupt	Little or no attempt to provide definite ending; students didn't realize lesson was over
S	NI	U

1698

PRACTICE AND EVALUATION SESSION SELECTED DISCUSSION TOPICS

Alcohol Awareness/Concerned Drinker Seminar

1. Part II - Film, "Alcohol," and Guided Discussion, pages 7-9. (Use of this topic depends on film availability.) DEVELOPED

2. Part IV - Scope/Impact of Alcohol Use in the United States. (Select any three of the sixteen specific topics.) LESS DEVELOPED

3. Part VI - Effects of Alcohol: DEVELOPED

1a. Short-Term Effects -

1b(1)(e). Long-Term Effects - Malnutrition. (Pages 26-29 (first sentence))

4. Part VI - Effects of Alcohol: DEVELOPED

1b. Long-Term Effects - Entire Section (1) Physiological Effects and (2) Alcohol Dependence. (Pages 27-29)

5. Part VII - Stages of Alcoholism: (Select any three consecutive stages.) (Pages 32-35) DEVELOPED

6. Part VIII - Responsible Drinking; Values Clarification, 1-2. (Page 43) LESS DEVELOPED

7. Part VIII - Responsible Drinking: Values Clarification, 3. (Pages 43-44) LESS DEVELOPED

Responsible Drinking: Using Alcohol Wisely (entire section). (Pages 50-51)

8. Part VIII - Responsible Drinking: Decision-Making Situation, 1. (Pages 53-54) LESS DEVELOPED

Drug/Alcohol Awareness Seminar for Commanders/Supervisors/First Sergeants

1. Objective 1 - Entire Objective (Pages 17-19). LESS DEVELOPED

2. Objectives 2 and 3 - Entire Objectives (Pages 20-21). DEVELOPED

ATTACHMENT 4

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3. Objective 4 - Drug Rehabilitation Stages (1)-(3). (Pages 22-24 (first teaching step)) DEVELOPED

4. Objective 4 - Drug Rehabilitation Stages (4), (5). (Pages 24-26) DEVELOPED

5. Objective 4 - Alcohol Rehabilitation Stages (1), (2). (Pages 26-29) DEVELOPED

6. Objective 4 - Alcohol Rehabilitation Stage (3). (Pages 29-30) DEVELOPED

7. Objective 5 - Entire Objective. (Pages 30-31) DEVELOPED

8. Objective 6 - Entire Objective. (Pages 32-33) DEVELOPED

9. Option I - Applied Techniques, Decision Exercise. (Pages 38-45) LESS DEVELOPED

NOTE: Create a situation similar to the one provided in the seminar and develop appropriate guidelines for processing it, using guided discussion techniques. Do Not use the same exercise.

USAF SUBSTANCE ABUSE SEMINAR

1. Objective 1 - Air Force Policies DEVELOPED

2. Objective 2 - Local Conditions DEVELOPED

3. Objective 3 - Socio-Pharmacology (Effects of Illicit Drugs) DEVELOPED

4. Objective 4 - Socio-Pharmacology (Therapeutic uses of Prescription substances) DEVELOPED

5. Objective 5 - Socio-Pharmacology (Effects of over-the-counter substances) DEVELOPED

6. Objective 6 - Responsible Actions DEVELOPED

7. Situation 1 - Pressure to Use Grass LESS DEVELOPED

8. Situation 2 - Choices on Visibility LESS DEVELOPED

9. Situation 3 - Responsible Drinking LESS DEVELOPED

10. Situation 4 - Asprin LESS DEVELOPED

11. Situation 5 - Choices about Rationing LESS DEVELOPED

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SOCIAL ACTIONS TRAINING BRANCH
Lackland AFB, Texas 78236

LP 8B-V-2(1)
1 August 1978

GUIDED DISCUSSION METHOD PERFORMANCE TEST

STUDENT _____ GROUP _____ DATE _____

INSTRUCTOR _____ ☐ Practice ☐ Evaluation ☐ Remake

PREPARATION: (Grading info on reverse)	U	N/I	S	COMMENTS
1. Objectives				
a. Appropriate number.				
b. Behavior to be learned specified.				
c. Appropriate subjects.				
2. Lesson organized in logical sequence.				
3. Content sufficient to meet objectives.				
4. References				

PRESENTATION: (Grading info on reverse)	U	N/I	S	COMMENTS
1. Introduction				
a. Attention gained	0	1	2	
b. Motivation	0	2	4	
c. Overview	0	0	2	
2. Objectives Met ***	0	6	13	
3. Clarity of Presentation				
a. Verbal support	0	1	2	
b. Transition	0	1	3	
c. Interim summary	0	2	3	
d. Visual-aids	0	2	3	
4. Pacing the Lesson				
a. Lesson timing ***	0	2	4	
b. Internal timing	0	2	4	
c. Progression by student needs	0	1	2	
5. Instructor Qualities				
a. Physical qualities	0	0	1	
b. Vocal qualities	0	1	3	
c. Instructor attitude	0	3	5	
6. Questioning Techniques				
a. Types of questions	0	5	10	
b. Elicits student participation	0	5	10	
c. Guided and controlled	0	5	10	
7. Provides Opportunity for Discussion	0	5	10	
8. Conclusion				
a. Summary	0	2	4	
b. Remotivation	0	1	4	
c. Closure	0	0	1	

TOTAL POINTS _____

_____
Student Acknowledgement

Attachment 1

DESIGNED FOR ATC COURSE USE. DO NOT USE ON THE JOB.

1701

GRADING INFORMATION

PREPARATION: All areas must be graded "Satisfactory" to receive satisfactory grade.

PRESENTATION: You may be graded "Needs Improvement" for some of the elements and receive a satisfactory grade on the Performance Test as long as you score at least 70 points and are within the time requirements.

***Automatic Presentation Failure

2. Objectives met - three or more teaching steps not presented or developed as planned.

4a. Lesson timing - lesson duration less than 28 minutes or more than 52 minutes.

GRADING INSTRUCTIONS

U - (Unsatisfactory) = 69 and below
S - (Satisfactory) = 70-90
ER - (Exceeds Requirements) = 91-100
NI - Needs Improvement

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PLAN OF INSTRUCTION/LESSON PLAN PART I

NAME OF INSTRUCTOR	COURSE TITLE
	Drug and Alcohol Abuse Control

BLOCK NUMBER	BLOCK TITLE
VI	Group Facilitation Techniques

1 COURSE CONTENT

1. Group Facilitation Techniques

GROUP FACILITATION TECHNIQUES (Groups and Facilitator Techniques)

a. Identify essential information concerning groups and group facilitator techniques.

GROUP FACILITATION TECHNIQUES (Decision-Making Process)

b. Identify basic information concerning decision-making processes in small groups.

c. In the small group setting, demonstrate an ability to manage group task functions in accordance with the criteria listed on the Task and Maintenance Functions Progress Test.

d. In the small group setting, demonstrate group maintenance functions in accordance with the criteria listed on the Task and Maintenance Functions Performance Test.

GROUP FACILITATION TECHNIQUES (Group Counseling)

e. Identify basic group counseling techniques.

f. Given a 40-minute role-played or real group problem, facilitate group counseling so as to resolve the problem in accordance with the criteria listed on the Group Counseling Performance Test.

g. In the day to day interaction in the school environment, participate in a manner which demonstrates characteristics conducive to constructive and healthy communication in accordance with the criteria listed on the Interpersonal Communications Performance Test.

SUPERVISOR APPROVAL OF LESSON PLAN (PART II)

SIGNATURE AND DATE	SIGNATURE AND DATE

PLAN OF INSTRUCTION NUMBER	DATE	PAGE NO.
L3ALR73430B/L30LR7361B/L30ZR7364B	30 May 1978	49

ATC FORM OCT 75 133 PREVIOUS EDITION IS OBSOLETE

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SUPPORT MATERIALS AND GUIDANCE

Student Instructional Materials
SW B-VI-1-1, Group Facilitation Techniques

WS B-VI-1-8, What to Look for in Groups
PT B-VI-1-9, Task and Maintenance Functions Performance Test

Audio-Visual Aids
35mm Slides, Group Facilitation Techniques
16mm Film, "Because That's My Way" (FLC2-122, 55 min)

Training Methods
Lecture
Small Group Facilitation/Performance

Instructional Guidance
Point out essential facilitator qualities, skills, and techniques; phases of group process and appropriate phase interventions; how to accomplish task and maintenance functions; and the roles facilitators must assume in order to facilitate group interaction. Demonstrate group facilitation techniques through the use of structured experiences. Demonstrate methods of opening a group, setting group goals, setting personal goals in a group setting, the importance, methods of observing and validating non-verbal behavior. Have students observe and summarize verbal interactions and gain practice in giving feedback in effective ways. Have the group give each student feedback on how they are accomplishing task and maintenance functions. Explain the HO, "What to Look for in Groups" to students. Have them use this HO in giving feedback to group members after observing group process of subgroups within the group. Give feedback on both verbal and non-verbal behavior. Help students become aware of group member perceptions of how they are functioning in the group through the sociogram exercise.

Explain the decision-making processes and the consequences which can occur from the use of these processes. Give students the opportunity to participate in decision-making tasks to apply the information learned about decision-making. Use role-played examples of on the job applications of this information. Demonstrate methods of group conflict resolution. Observe another group's functioning and give feedback to the other group's members.

Explain basic group counseling techniques to include: Behaviors clients need to learn while participating in groups; appropriate facilitator interventions; and methods of invitational counseling; methods of starting and closing groups. Have each group member facilitate a 40-minute role-played group of alcoholics or a real group problem, and give them feedback. Use appropriate methods for closing out the small group as graduation approaches.

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Performance exercises and tests will be conducted in the following manner: Students will practice good interpersonal communication (which were learned in Block I, Personal Growth and Professional Development) throughout the course. Their goal is to improve their interpersonal communications with each successive day. Give them feedback over their performance during the periods: Day 10-18, 19-26, and 27-40. The first two periods will be considered performance exercises (practice sessions), and the final period will be considered the performance test. Use the Interpersonal Communication Performance Test to document this feedback.

Students must learn to identify and use task and maintenance functions to facilitate group interaction. Give them practice in observing group process and use of these functions during the period Day 10-18. The evaluation period for task and maintenance functions will be the period Day 19-26, with a final grade given on Day 18 using the Task and Maintenance Function Performance Test.

Students use good interpersonal communication and task and maintenance functions along with the group counseling techniques presented in order to conduct group counseling. Each group member will assume the responsibility of being group facilitator/counselor for one 40-minute period. The student will be graded on his/her performance during that 40-minute session using the Group Counseling Performance Test.

When conducting group facilitation the facilitator/instructor must constantly keep both progression by student needs and meeting the educational objectives in mind. Emergency needs of the student should be dealt with during the group; however, personal problems uncovered in the group should be postponed, where possible, until the objectives are met and/or until individualized special assistance or referral can be scheduled. When there is not sufficient time remaining to meet the objectives due to individual assistance, the group should be scheduled for remedial training as soon as possible. In no case should instructors skip or delete covering the group tasks or objectives. Discuss any deviations with the instructor supervisor so that scheduling problems may be resolved. If a student is having a significant problem meeting objectives, or if a personal problem is interfering with the individual's performance, insure that you brief the instructor supervisor.

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STUDY GUIDE AND WORKBOOK

3ALR73430B/3OLR7381B/3OZR7384B-VI-1-1

Technical Training

Drug and Alcohol Abuse Control

GROUP FACILITATION TECHNIQUES

1 August 1978

USAF Technical Training School
Lackland Air Force Base, Texas 78236

Designed For ATC Course Use

DO NOT USE ON THE JOB

1128

1706

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Looseleaf ISBN: 0-88390-078-5
Hardbound ISBN: 0-88390-080-7
Paperbound ISBN: 0-88390-079-3

Library of Congress Catalog Card Number 73-92841

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Social Actions Training Branch
Lackland Air Force Base, Texas

30LR7361B/30ZR7364B-VI-1-1
1 August 1978

GROUP FACILITATION TECHNIQUES

OBJECTIVES

Identify essential information concerning groups and group facilitator techniques.

Identify basic information concerning decision-making processes in small groups.

Identify basic group counseling techniques.

INTRODUCTION

Facilitators need to be aware of these qualities, skills, and techniques in order to insure that the objectives of the group will be accomplished.

INFORMATION

FACILITATOR QUALITIES, SKILLS AND TECHNIQUES

Qualities

Qualities are the personal characteristics necessary to promote effective group functioning. As a model, the facilitator sets the stage for other group members to copy in their everyday group interactions.

EMPATHY. Being able to accurately perceive what another person is experiencing and communicating to you. Sometimes a facilitator may find the use of analogies and metaphors to be most helpful in showing empathy. For example: "You are feeling tired, and that is like having a heavy load on your back."

ACCEPTANCE. Acceptance means to promote an atmosphere in which there is an absence of threat or judgment. This atmosphere is often called unconditional positive regard. Each person is treated as an individual of dignity and integrity; it involves situations characterized by warmth, friendliness, and acceptance of members as they are. This atmosphere will allow members to explore their personal meanings more effectively. Acceptance requires a kind of self-discipline, understanding, and sensitivity to other people. When others' values differ from your own, you should recognize the difference and accept their right to be different. In order for persons to accept someone else, they must first accept themselves. There must be and attitude of willingness to look at and consider the facts. Acceptance is understanding without judging. Acceptance requires an openness to experience which provides the only sound basis for growth. It is an attitude of taking people as they are and moving forward from this point. Acceptance of where a person is does not mean we must be resigned to leave them there. Facilitation is to help people move, change, and grow at their own pace and by their own choice. Facilitation is an active process encouraged by the kind of accepting atmosphere you, the facilitator, can create. Acceptance is conducive to the exploration of personal meaning.

Supersedes SWB-II-10-20, Nov 76 and HO B-II-10-22, Aug 76.

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CONGRUENCE. The rule of congruence states that you should be real and genuine in your relations with group members. You should remain in touch with your feelings and act on those feelings.

FLEXIBILITY. Flexibility is the art of avoiding being so rigid that you cannot afford to listen to others. You should be able to adapt to whatever the situation is.

Skills

Skills are those attributes that a facilitator possesses that will enable the group to accomplish its objectives. Helpful skills are:

LISTENING. Listening is reaching out for what another person has to say. A facilitator should learn to pick up all the cues that others throw out whether they be verbal or nonverbal. Facilitators should be sensitive to messages that are not identified with the verbal content of the conversation.

EXPRESSING ONE'S SELF. Expressing one's self refers to being able to give others your messages clearly (both overtly and covertly).

RESPONDING. Responding refers to communication with others. It requires a heightened awareness and sensitivity to the members to whom you are responding so that you are able to communicate within a system that has meaning for them.

OBSERVING. Observing (behavior) involves watching to see who talks and for how long and how often. The facilitator needs to be concerned about: (1) whom do people look at when they talk, (2) do they single out others for potential support, (3) do they scan the group or look at no one, (4) who talks after whom or who interrupts whom? Another important aspect of observing involves the style of communication used. The styles may fall into these categories: assertions, questions, voice tones (different), gestures or some other significant style.

INTERVENING. Intervening means to remain objective and suggest negotiation between group members.

DESIGNING. Designing involves asking yourself, what might this group need and how might we give it to them or help them get it themselves.

Techniques

Techniques are the methods that facilitators use to teach group members to apply the group procedures they are learning in groups.

STRUCTURED EXPERIENCES. Structured experiences implement an experiential model that has five revolving steps:

Experiencing. Experiencing involves the participants in some activity; they act or behave in some way or do, perform, observe, see, or say something.

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Publishing. Publishing is sharing reactions and observations with others who have either experienced or observed the same activity.

Processing. Processing is the integration of that sharing. The dynamics that emerged in the activity are explored, discussed, and evaluated (processed) with others.

Generalizing. Generalizing calls for developing participants' principles of extracting generalizations from the experience. Stating learning in this way can help participants further define, clarify and elaborate them.

Applying. Applying means to plan applications of the principles derived from the experience. The experiential process is not complete until a new learning or discovery is used and tested behaviorally. This is the "experimental" model. Applying, of course, becomes an experience in itself, and with new experiences, the cycle begins again.

INSTRUMENTS. Instruments are vocational interest inventories, and other personality tests, but you should use these only if you are qualified to do so. You can make arrangements with the mental health center or base education office to work joint programs for group members to find out more about themselves.

LECTURETTES. Lecturettes are used to increase students' awareness of the cognitive (thinking or comprehending) aspects of the group experience.

CONFRONTATIONS. Confrontations are most beneficial when there is a discrepancy between what one is doing and what one is saying — when there is incongruence.

EXERCISE I

Complete the following exercise.

1. What are the essential facilitator qualities necessary for effective group facilitation?

2. Which skills are essential for effective group facilitation?

3. What are the techniques a facilitator can use in group facilitation?

STAGES OF GROUP PROCESS AND APPROPRIATE INTERVENTIONS

Stage One — Gathering Together

Gathering together may have a time period of 10 or more sessions.

ISSUES. The issues to be concerned with in this stage are: inclusion, what to do and identity loss.

INTERVENTIONS. Interventions include: role clarification, trust building, modeling and safety.

Stage Two — Standstill

Standstill is usually the most troublesome stage because of the issues involved.

ISSUES. The issues in this stage are: letting go, fear, anger, challenge and resistance.

INTERVENTIONS. The facilitator should intervene to challenge "either/or" options when these are made instead of both/and options. They can expand these options, use structured experiences or down play past history. The movement concludes when there is general agreement that change is in fact possible in the group, whether it is changing behavior, making a decision, or solving a problem.

Stage Three — Biting Through

Biting through involves a heightened arousal of feeling and a greater need for nourishment.

ISSUES. The issues in this stage are: conflict, experimentation, flux, power, group identification.

INTERVENTIONS. Interventions are concerned with reality orientation, confrontation and "both/and" attitudes which replace either/or thinking. Power and authority are seen as residing both in the group and in its members. It is the central period in many theories of

group development. When the smoke clears and new learnings (insights, solutions) are apparent, the movement concludes and enters the fourth stage.

Stage Four – The Taming Power of the Great*

This stage is governed by the interaction/silence polarity. The group creatively achieves a degree of synergistic fusion. The feelings are focused on the new and the now. Reflective, meditative, incorporative silence coexists with playful and pleasurable interaction with others.

ISSUES. The issues involved in stage four are: testing out, integration, affection and contracting.

INTERVENTIONS. The best interventions to make in this stage are no interventions at all. The facilitator begins to let go. Much work is accomplished; previously difficult issues are simply and easily resolved.

EXERCISE II

Complete the following exercise.

1. What is the most troublesome group stage?

2. Role classification is most common in which stage?

3. Which stage is thought to be the central period of group development?

4. Where does the facilitator begin to let go?

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TASK AND MAINTENANCE FUNCTIONS

Task and maintenance functions are essential for effective group facilitation. Task is the content and maintenance is the process. Both are essential for group functioning. We will be discussing task functions first then look at maintenance functions.

Task Functions

Task functions are those skills that facilitate going about doing the group's work. Their purpose is to facilitate and coordinate group effort in the selection and definition of a common problem and in the solution of that problem. Task functions include the following:

SETTING GOALS. This is simply suggesting objectives for the group on which to work. It involves proposing a task or goal, defining a group problem; suggesting a procedure.

SOLVING PROBLEMS. Suggesting steps for solving problems. The member demonstrates a capability to analyze problems. They spell out suggestions in terms of examples or developed meanings, offer a rationale for suggestions previously made, and try to deduce how an idea or suggestion would work out if adopted by the group

MAKING DECISIONS. Deciding between alternative suggestions for group actions and offering a decision or conclusion for the group to accept.

INTEGRATING IDEAS. Pulling together related ideas and restating suggestions after the group has discussed them. They show or clarify the relationship among various ideas and suggestions, try to pull ideas and suggestions together, or try to coordinate the activities of various members or subgroups.

TESTING CONSENSUS. Asking to see if the group is nearing a decision, sending up a trial balloon to test a possible conclusion.

BEING IN CONTROL. Initiating action and taking own responsibility especially when the group is dragging.

BEING PRODUCTIVE. Offering a variety of ideas to the group; facts and revelant information about group concerns. They may offer facts or generalizations which are "authoritative" or relates their own experience pertaining to the group problem.

BEING INVENTIVE. Suggesting or proposing to the group new ideas or a changed way of regarding the group problem or goal. The novelty proposed may take the form of suggestions of a new group goal or a new definition of the problem. It may take the form of a suggested solution or some way of handling a difficulty that the group has encountered. It may take the form of a proposed new procedure for the group, a new way of organizing the group for the task ahead.

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Maintenance Functions

Maintenance functions are those skills that promote the atmosphere and inducement. They are the functions that promote participation. Because of these functions the group functions as a group and, therefore, promotes effective task functions. They include:

HELP OTHERS CONTRIBUTE. Helping to keep communication channels open; gate keeping; suggesting procedures that permit sharing remarks. Facilitators accomplish this function by inviting other group members to participate. The best method is to ask them questions. ("We have not got the ideas of Mr. X yet," or "Why don't we limit the length of our contributions so that everyone will have a chance to contribute.")

ACCEPTING OTHERS' FEELINGS. Being nonjudgmental. The most appropriate method is by verbal expression to let other members know that it is okay to be different. It is characterized by exhibiting tolerance and not being critical of other members' feelings. Characteristics of this function include: praise, agreement, and acceptance of the contributions of others. The members indicate warmth and solidarity in their attitude toward other group members, offer commendation and praise, and in various ways indicate understanding and acceptance of other points of view, ideas, and suggestions.

EXPRESSING GROUP FEELINGS. Sharing perceptions about the group. That it is anxious, apathetic, or dependent.

REVIEWING GROUP PROCESS. Reviewing how the group is functioning; i.e., how the group is making decisions, are all the members participating and who controls the group. They keep mental records of various aspects of group process and feed such data with proposed interpretations into the group's evaluation of its own procedures.

STIRRING THINGS UP. Being a catalyst who causes an action or reaction between two or more persons by something they say or do. They may provoke the group into some kind of action/reaction by a question or verbal statement. ("It appears to me that the two of you have decided to support each other," or "When group member B gets into difficulty you seem to rescue him/her," "What's that all about?") Prods the group to action or decision, attempts to stimulate or arouse "greater" or "higher quality" activity.

HARMONIZING AND COMPROMISING. An attempt to reconcile disagreements; reducing tensions; getting people to explore differences. These members usually operate from within a conflict in which their ideas are involved. They may offer compromises by yielding status, and admitting error, by disciplining themselves to maintain group harmony, or by a coming halfway in moving along with the group. The member may also pour oil on the troubled waters in a conflict situation.

ENJOYING THE PROCESS. This is characterized by showing involvement and eagerness. Facilitators create interest and excitement and invite others to do so.

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GIVING INTERPERSONAL FEEDBACK. Providing appropriate feedback to others about their behavior in the group. The feedback should be descriptive, specific, meet needs of both receiver and giver, be about behavior receiver can do something about. It should be well timed and checked to insure clear communication. An important aspect is to insure that the feedback is solicited.

EXERCISE III

Complete the following exercise.

1. What are task functions?

2. Which task function demonstrates a capability to analyze problems?

3. How can a group member be inventive?

4. What is meant by testing consensus?

5. Which maintenance function is accomplished by inviting other members to participate?

6. How does a facilitator let others know that it is okay to be different?

7. How does a facilitator reconcile disagreements?

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FACILITATOR ROLES

ROLE REQUIREDNESS. Role requiredness implies that different roles are needed at different times. The facilitator needs to ask "what is needed now?" "Do I need to help others contribute or problem solve?" On other occasions the role called for may be that of integrating ideas or giving interpersonal feedback. You should be aware of the fact that no one will be exhibiting every role all the time, but rather the fact that each situation calls for a particular and different role.

ROLE FLEXIBILITY. Role flexibility means that the facilitators take different roles as needed. They should be flexible enough to take on whatever role is necessary for a particular situation. If "taking control" is the only role a facilitator can assume, then this person is very limited.

EXERCISE IV

Complete the following exercise.

1. What does the term "role requiredness" mean?

2. Describe role flexibility in terms of group facilitation.

SUMMARY

The essential facilitator qualities were: empathy, acceptance, congruence and flexibility. Those skills associated with effective facilitation were: listening, expressing one's self, observing, intervening and designing. Finally, the techniques involved: the use of structured experiences, instruments, lecturettes and confrontations.

Group development included the discussion of four stages: gathering together, stand-still, biting through and the taming power of the great.

Task functions are those skills that facilitate going about doing the group's work. These were: setting goals, solving problems, making decisions, integrating ideas, testing consensus, being in control, being productive and being inventive.

Maintenance skills are those skills that promote participation. These facilitator skills were: helping others contribute, accepting others' feelings, expressing group feelings,

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reviewing group process, stirring things up, harmonizing and compromising, enjoying the process and giving interpersonal feedback.

Role requiredness means that different roles are needed at different times, and role flexibility means that the facilitator takes different roles as needed.

Remember this information will increase your effectiveness as a group facilitator. By understanding and applying this information in groups here in school, you will develop the skills and techniques needed to be a successful facilitator in the field.

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ANSWERS TO EXERCISES

Exercise I

1. Empathy, acceptance, congruence, and flexibility.
2. Listening, expressing one's self, responding, observing, intervening and designing.
3. Structured experiences, instruments, lecturettes and confrontations.

Exercise II

1. Standstill.
2. Gathering together.
3. Biting through.
4. The taming power of the great.

Exercise III

1. Those skills that facilitate going about doing the group's work.
2. Solving problems.
3. Suggest or propose new ideas or a changed way of regarding the group problem.

4. By asking "are we in agreement."
5. Helping others to contribute.
6. By accepting others' feelings.
7. By harmonizing and compromising.

Exercise IV

1. Different roles are required at different times.
2. Facilitators take different roles as needed.

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YIN/YANG: A PERSPECTIVE ON THEORIES OF GROUP DEVELOPMENT

Anthony G. Banet, Jr.

All human groups are living and ever changing. Issues that were critical in the first session evaporate by the fourth session; the excitement of session three is followed by the ennui of session seven. Moods fluctuate, central concerns wax and wane. The group has a life of its own; its primary characteristic is movement. Groups, like individuals, are unique, but all groups share some similar attributes. These observations, made repeatedly by students of groups, are the bases for theories of group development—statements about the flow of group process over time.

The literature in the fields of group psychotherapy, group dynamics, organization development, and human relations training yields an abundance of theories of group development. Tuckman (1965) reviews sixty-two theories; Hill (1973), once a connoisseur of group theories, states that he ended his hobby when his collection numbered over one hundred specimens. Although theories abound and spring from various observational data, underlying similarities can be discerned.

Three different models of group development emerge: the *linear* model, which regards change as a progressive, straight-line function over time; the *helical* (spiral) model, which sees change as a regressive, whirlpool movement from surface to core issues; and the *cyclical* model, which views change as an interplay of yin and yang energy forces. Approaches to a potential integration of these models are here suggested.

FUNCTIONS OF GROUP-DEVELOPMENT THEORIES

Theories of group development serve descriptive and predictive functions. For the group practitioner, the theory also provides a framework for interventions.

On a descriptive level, developmental theory permits the observer to organize his perceptions. During a given slice of group life, verbal behavior, the interaction pattern, emotional climate, or type of content can be characterized and measured. Whatever the observational base, descriptions of group phenomena in a given session can be compared and contrasted with those from a past or future session.

Used predictively, developmental theory enables the observer to forecast the group's future process. The theory describes what *should* be happening, at least under ideal conditions, so that objectives can be set. The predictive aspect offers comfort to the group practitioner: events will not always be as conflicted or sluggish as they appear to be in a given session.

A particular theory also provides the group leader with cues for specific interventions. The leader may want to accelerate the process, slow it down, or freeze or focus it to insure that a group does not avoid or ignore opportunities for learning. Equipped with theory, the leader may plan or design interventions intended to surface and clarify process issues that he regards as important. Developmental theory is a particularly helpful guide to amplifying issues that groups frequently find troublesome: dependency, authority, conflict, power, and intimacy.

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Content, Process, and Structure

In a group-development theory, the content, process, and structure of a group are closely interrelated. Content, *what* is being said, verbally and nonverbally, is determined by the group's task, whether it is to make decisions, overcome resistances to growth, or experiment with new behavior. Process refers to *how* a group behaves; process elements include events happening inside individual members, group-level phenomena such as norm development, and contextual (past history, back-home) variables. In the life of a group, content and process are always happening, but the visibility of the process is a function of group structure.

Structure serves as a valve to control the flow of energy between process and content. The structure of the group, which includes such elements as the leader's attitude toward the group and the theory he espouses, determines the extent to which content and process are allowed to interrelate and to influence each other. Structure also includes the group's objectives, the contract between the leader and the group, and the ground rules to which the group subscribes. To a lesser extent, structure also refers to the physical environment in which the group lives.

Group structure can be tight and rigid, permitting no process elements to become part of the group's agenda. or it can be so loose that the process becomes the content, as in a T-group. To some extent, the profusion of group-development theories is a result of the variety of group structures. A loose structure may allow fifteen phases of process to surface; a tight structure, only one or two.

The group's structure enables the practitioner to place a selective value on specific process elements and to make decisions regarding the focus of the group. Each intervention becomes a creative decision to enrich the ongoing content with relevant process phenomena. Too much or too little attention to process endangers the group's task function—its reason for being.

At present. no single theory of group development adequately accounts for all group phenomena reported by observers. Events that are commonplace in a Tavistock conference, for instance, may never surface in a team-building session. Individual "implosions" occur in a Gestalt workshop, but rarely in a communication-skills laboratory. Some groups spend half their life working authority issues; others focus on the issue for only minutes before moving on to long periods of affection and intimacy.

These discrepancies seem attributable to the power of a theory of group development to "make it happen"; that is, the theory, as an observational tool, impacts what is being observed. As Butkovich et al. (1975) state in a recent study, there is a strong "possibility that the group leader's theoretical orientation, as it is reflected in his interpretations and behavior, is causally related to the very group behavior being interpreted" (p. 9).

This contamination by the observer of what is being observed is prevalent in all applied behavioral science. Contamination does not discredit a theory but serves to remind us that "truth" is always filtered through a human observer with built-in biases and distortions. However, contamination does raise the difficult methodological issue that some process elements (transference, for example) may in truth be artifacts of the observational tool employed. What is reported as a group-process event may exist, instead, only in the minds of the intervener. As Lundgren (1971) has demonstrated, the pace and pattern of group process, as well as specific group phenomena, are directly related to the intervention stance prescribed by the leader's theory of group development. Therefore, a primary problem in the study of group development theories is distinguishing between the observer and the data.

Another factor accounting for a less-than-comprehensive theory is that different developmental theories focus on different elements of group process. Theories described here as employing a *linear* model focus on group elements of process: the interaction system, group emotion, then normative system, group culture, and the executive system. The linear model views process as progressive. The *helical* model focuses on contextual elements: transferential, past history aspects of process, including physical and social contacts, emotional and contractual relations, and the

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individual's attitudes toward authority and control. The helical model views process as regressive. The *cyclical* model focuses and amplifies those process elements contributed by the indivdual member: behavior style; personal feeling state; internalized norms, beliefs, and values; and the ego of the individual. The cyclical model views process as a transcendence of polarities. These elements of process are discussed more fully by Banet (1974).

THE LINEAR MODEL

The group process is viewed by the linear model as an orderly, sequential, progressive movement over time, a straight-line function that passes through predictable phases or stages of growth, paralleling individual growth from conception to maturity. In the linear model, the group is a temporary, intentional community of workers or learners who have banded together to reach some goal. The community life of the group has a definite beginning, middle, and end.

The actual number of phases seen by linear theorists varies considerably, from two (Bennis & Shepherd, 1956) or three phases (Schutz, 1973; Kaplan & Roman, 1963) to ten (Cohen & Smith, 1976) to fifteen (Rogers, 1970). Despite this range of stages, theories embracing the linear model share many similarities. Two representative theories are discussed here: Schutz's theory of interpersonal needs (Schutz, 1967, 1973) and Tuckman's developmental sequence (Tuckman, 1965).

Schutz's Theory

For Schutz, the initial stage of development for the group is the *inclusion* phase. Major inclusion issues revolve around boundaries, building trust and commitment, determining who is a member and who is not, and maintaining individuality while simultaneously being a group member. Group members are motivated by fear, curiosity, excitement, and the need to include or to be included.

As inclusion issues become resolved, the group moves into a *control* phase, in which concerns of power, dominance, authority, and responsibility are prominent. Feelings of anger, helplessness, and incompetency motivate members to deal with personal power, the authority of the leader, and the influence of other group members. This middle phase is critical for all linear models—it is a period in which the group either disintegrates or becomes cohesive. It is a turning point in the life of the group; if the control phase is avoided, denied, or ignored, group development is retarded.

Following the middle phase is a concluding period of *affection*, cohesion, and intimacy. Major issues are (1) how close or how distant group members want to be with each other, (2) giving and receiving warmth, and (3) how much sharing and disclosure is productive and appropriate. When this phase moves toward conclusion, the life of the group begins to terminate. For Schutz, termination involves a reversal of the stages: affectional relations are ended first, then control relations, and finally inclusion.

Tuckman's Sequence

Having reviewed many theories, Tuckman (1965) postulates that the first stage of group life is one of *testing and dependence*. The group orients itself to group living, testing which behaviors are acceptable and which are taboo. Much attention is focused on the group leader, as group members grope to define their task and their boundaries.

Stage two is a period of *intragroup conflict*. Issues of power and competition dominate group life; the mood of the group is highly emotional and rebellious.

When conflict issues are settled, stage three—*group cohesion*—emerges. In the third stage of group life, openness, positive feedback, and expressions of affection are characteristic.

Stage four is described as a period of *functional role-relatedness*. It is a work stage, characterized by a minimum of emotional interaction. The atmosphere of the group encourages and

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supports task completion; obstacles have been removed in previous stages. When the group completes its task, it terminates.

Tuckman succinctly describes his four phases of group life as "forming, storming, norming, and performing."

Characteristics of the Linear Model

The group elements of process—the interpersonal communications network of the community of learners—are the focus of the linear model. While linear theories recognize that all group members may not be in the same psychological place at the same time, the theories assert that certain critical "barometric events" (Bennis & Shepherd, 1956) bring individual members to a similar awareness; thus, *in general*, the members of a group can be regarded as being in a given phase at a given time. The model implies that all groups, regardless of size or task, deal with the same issues in the same sequence.

The intervention style derived from the linear model emphasizes building awareness of the phases of development, amplifying issues specific to a given phase, and preventing premature movement. In fact, a major concern of interventionists using the linear model is that members will tend to deny the existence of the difficult middle phase (power, control, conflict) in their eagerness to get to a cohesive, affectionate state.

The linear model enjoys broad usage. Many theories describing task groups, social systems, and work teams incorporate the linear view; for Schutz, the phases are most visible in the encounter group (Schutz, 1973). In part, the popularity of the linear model is due to its compatibility with the usual way of regarding personality development: in many such theories, the individual passes through phases until maturity is reached. See, for example, Erikson (1963) and Kohlberg (1964).

Several shortcomings of the linear model should be noted. As Hare (1973) comments, the assumption that a group moves from phase to phase needs further documentation, since linear theorists typically do not discuss the *process* of development in any detail; rather, they simply observe that one phase follows another. The model does not clarify how this sequencing happens, nor does it explain why one group may remain in a given phase for six months, while another passes that stage in three weeks.

The linear model reflects a world view that is peculiar to Western culture. Referring to the linear model as a "staircase" model, Kahn et al. (1974) list some important consequences of viewing development as a progressive, ever-upward moving line: such an attitude suggests that permanence is the only good, and that the top of the line is the only spot worth attaining. As Kahn and his associates see it, the linear model encourages judgment and categorization, rather than acceptance and experiencing, and focuses a group on future events, rather than on the present. In short, the linear model suggests that the destination is more valuable and important than the journey to it.

Theories using the linear model receive a fuller discussion in Bennis and Shepherd (1956), Charrier (1974), Cohen and Smith (1976), Gibbard, Hartman, and Mann (1974), Hare (1973), Jones (1973), Kaplan and Roman (1963), Rogers (1970), Schutz (1973), and Tuckman (1965).

THE HELICAL MODEL

The helical model of group development views the group process as a regressive, spiraling, ever-deepening focus on a few prominent issues peculiar to a given group. The themes and issues worked in the group follow no particular order; once a theme is surfaced, however, it will develop in a fairly predictable pattern, from its surface aspect to its deepest level of significance. Group process moves in a whirlpool fashion; it gains momentum and suctional power as it burrows deeper and deeper.

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The group is perceived as a metaphoric tribe which comes together to achieve security, physical safety, and support in times of stress. The group also provides members an opportunity to gain selfhood and significance (Klein, 1968).

At its inception, the group begins a regression away from its obvious, manifest level, down to its latent or hidden meaning. The group acquires allegorical and mythological meaning for its members (Dunphy, 1968); it may begin to recapitulate the dynamics of a primal horde (Ezriel, 1950), a primitive family, or a religious group. In other views, the group is seen as a microcosm (Slater, 1966), a re-enactment of the Oedipal conflict (Gibbard & Hartman, 1973), or the "good breast" of a nuturing mother (Scheidlinger, 1974). This regression to allegorical levels is encouraged by the structure of the group, especially the posture of the leader, in the belief that by reliving past events, a "corrective emotional experience" (Alexander, 1956) will occur, enabling the group and its members to gain a fresh perspective of self and to achieve perceptual and behavioral reorganization.

The group dwells in this regressive space for some period of time. Only after core issues such as dependency, autonomy, aggression, and sexuality are resolved does the group emerge from the depths of the whirlpool to work on present problems and solutions. During the regressive period, the group's process is erratic and disconnected, marked by conflict and motivated by strong, primitive emotionality. The group process re-enacts the turmoil and stress of childhood and adolescence: the flow is choppy and is frequently interrupted by new issues. In its regression, the group develops a cohesion (usually motivated by antagonism toward the leader) and takes on the characteristics of an organism that is in some ways greater than the sum of its parts.

Bion's Theory

Bion (1959) is the principal theorist of the helical model. His central notion is that in every group, two "groups" are actually present: the *work* group and the *basic-assumption* group. The work group is that aspect of group functioning that has to do with the real task of the group. For example, designing a program, passing a resolution, completing a report, or changing behavior are real tasks. But groups do not always function sensibly or productively—they do not always focus on the task. To explain why groups do not always work well, Bion introduced the notion of the basic-assumption group.

Basic assumption is an "as if" term. The group behaves *as if* a certain assumption is basic to its maintenance, growth, and survival. These basic assumptions are covert; they constitute the group's hidden agenda. The basic assumptions derive from the collective repressed feelings of all the group members.

From his experiences in groups, Bion identifies three distinct types of basic assumptions:

1. *Basic-assumption dependency*. The essential aim of this emotional state is to attain security and protection from one individual, usually the leader. The group behaves as if it is stupid, incompetent or psychotic; only a powerful, omniscient, God-like leader can perform the task functions. When the leader fails to meet the (impossible) demands of the group, it expresses its disappointment and hostility in a variety of ways.

2. *Basic-assumption fight-flight*. Here, the group assumes it can survive only if it flees from the task (by withdrawal, regression, or focusing on past history) or if it fights (by aggression, scapegoating, etc.). A leader who is accepted is one who is willing to afford the group an opportunity for flight or aggression.

3. *Basic-assumption pairing*. In this state the basic assumption is that the group has come together for reproductive purposes. Any bond between two or more group members is seen as a sexual bond that will give birth to a Messiah who will save the group by providing it with new life, new thoughts, and a creative way to work on the task. Magic is the solution that is hoped for.

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Turquet (1974) has added a fourth type of basic assumption—*basic-assumption oneness*, in which the group seeks to join in a powerful union with an omnipotent force, unobtainably exalted, to surrender itself to passive participation, and thereby to feel "existence," well-being, and wholeness.

The basic-assumption life of the group is oriented inward toward fantasy, not outward toward reality. The basic assumptions are anonymous; they cannot be attributed to any one member. Individuals vary in their readiness (which Bion calls "valency") to combine with a given basic assumption of the group. Some members, as well as the leader, may find it easier to collude with dependency themes, others with flight reactions, etc.

The work group requires concentration, skill, and organization of all resources in the group, as well as cooperation from its members. The basic-assumption group, on the other hand, exists without effort. A group will stay locked into its basic assumptions until some resolution is reached that permits the group to move on to a work level. The basic-assumption life of the group is never exhausted, but it can be deliberately bracketed or suppressed.

An excellent introduction to Bion's theory is provided by Rioch (1970); Colman and Bexton (1975) present extensions and applications of the basic-assumption approach.

Characteristics of the Helical Model

Providing the theoretical basis for many kinds of psychotherapy groups, the helical model has as a major strength its thoroughness in dealing with difficult issues and its unwavering belief that "the child is father to the man." The model attempts to provide group members with an opportunity to reorganize their current personality patterns by correcting the errors of the past. Like the linear model, which avoids the present moment by focusing on the future, the helical model avoids the now, but by focusing on the past. It stresses the belief that the past has much to teach us; we cannot confidently move on until we have digested its lessons. As Santayana said, "Those who do not remember the mistakes of history are condemned to repeat them."

Additionally, the model provides the group with an opportunity to confront the uncomfortable realities of life: pain, suffering, tragedy, and death. Through its focus on history, the model counterbalances the optimism and the idea of progress implicit in the linear model.

The helical model prescribes a central role for the group leader, who functions in the group not as a person but as a role—a role that encourages projection and regression. The coolness and distance of the leader quickly elicit basic-assumption behavior. As the group intensifies, the leader interprets, confronts, and weaves connections between present behavior and past experience, in an effort to make the unconscious conscious.

The intervention stance of helical-model theories focuses on contextual aspects of group process. Past history, emotional relations outside the group, and the individual member's position in relation to authority, responsibility, and control provide the primary process data for the group's considerations.

The leader's central role is a critical shortcoming of helical-model theories. The leader seems constantly to be saying to the group, "I see something you don't see." This posture creates dependency on the perceptual accuracy of the leader and his skill in surfacing and working with unconscious material. This dependency carries the implication that group work is a long-term investment for the group member.

Personality theories that stress the importance of early childhood experience—psychoanalysis, ego psychology, general psychodynamic theory, and transactional analysis—are compatible with the helical model of change.

Group theories using the helical model can be found in Bion (1959), Burrow (1928), Ezriel (1950), Foulkes and Anthony (1957), Gibbard and Hartman (1973), Saravay (1975), Scheidlinger (1974), Slater (1966), Slavson (1950), Whitaker and Lieberman (1967). For the most part, the psychotherapy group has provided the observational base for these theories.

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THE CYCLICAL MODEL

The group process is in constant motion, never at rest, in the cyclical model. The process is continuous and persistent; like the phases of the moon and tides, the seasons, and other natural phenomena, the group life moves through a cycle until it returns, with subtle alterations, to its starting point.

In the cyclical model, the group is a collection of individuals who have gathered together to divine the principle of change that governs their lives and to discover a way to order their behavior in accordance with that principle. The group is less a community than it is a theater—an energy field where individual growth and change unfolds.

No current theory of group development directly defines the cyclical model of change. However, the cyclical model is implied in the practice of those groups that focus on personal, individual change within the group context. The model provides a basis for understanding the Gestalt group and other groups that stress intrapersonal learning.

Philosophical Aspects

Because the cyclical model is not as well known as the linear and helical models, a discussion of its philosophical aspects is provided here. We live in a world of permanent change, where all phenomena are dynamic and in flux. This observation dates back at least to 500 B.C., when Heraclitus in Greece and Confucius in China compared the constant movement of experience to the everchanging flow of a river.

The dynamism of experience has met different responses in Eastern and Western thought. Western thinkers have tended to abstract from experience, "freezing" phenomena so that they can be subjected to scientific investigation. Hence, change tends to be seen in a linear mode, a static progression from phase to phase.

In contrast, the Eastern mode has been to acknowledge the flow of experience and to search for the law of change, itself unchanging, which governs this flow. The name given to this governing principle is *Tao*. *Tao* is one; out of *Tao* comes the energy of yin, the receptive principle, and yang, the active principle. Change is viewed as natural movement and development, in accord with *Tao*. The opposite of change is regression; as H. Wilhelm (1960) puts it, "the opposite of change in Chinese thought is growth of what ought to decrease, the downfall of what ought to rule" (p. 18).

Tao defies definition, as Chung-yuan (1963) states: "The understanding of *Tao* is an inner experience in which distinction between subject and object vanishes. It is an intuitive, immediate awareness rather than a mediated, inferential or intellectual process" (p. 19). The *Tao* is the way, the ultimate principle, the great interfusion of being and nonbeing. Despite this ineffability, the yin/yang energy flowing from *Tao* has acquired highly practical embodiments in Chinese culture: acupuncture, T'ai Chi and other martial arts, centering, calligraphy—all are manifestations of and approaches to *Tao*.

The *I Ching*

Perhaps the most eloquent description of the interplay of yin/yang energy is in the ancient oracle and scripture, the *I Ching*. The *I Ching*, or Book of Changes, applies this concept of change to human phenomena—individual lives, groups, and organizations. It proposes a cyclical theory of change, change as a movement that returns to its starting point. Change is orderly, as is the movement of the tides or the seasons, but its orderliness is not always perceptible. In human situations, the forces of yin and yang produce complex configurations. As a book of wisdom, the *I Ching* invites its user to pursue *Tao*, a state of resonance with the Oneness of actuality (Dhiegh, 1974), by discovering the proper time for correct action.

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The *I Ching* has as its basis the two fundamental principles of *yin*, characterized as the receptive and the docile and symbolized by the broken line (— —), and *yang*, characterized as the creative and active and symbolized by an unbroken line (———). In sets of three, the broken and unbroken lines compose the eight *pa kua* (trigrams), signs associated with natural phenomena and basic aspects of human experience.

Combined in all possible ways, the eight *pa kua* produce sixty-four six-line *kua* (hexagrams) which symbolize various elementary aspects of the human condition: primary needs, such as nourishment; personality-development milestones, such as breakthrough, pushing upward, or retreat; social situations, such as marriage, following, conflict; and individual character traits, such as modesty, grace, and enthusiasm. The sixty-four hexagrams comprise a psychological "periodic table of elements" from which immediate, here-and-now situations are composed.

The eight *pa kua* provide descriptions of the basic polarities of life:

1. Ch'ien (☰), the creative, heaven. The sign is associated with energy, strength, and excitement. It represents the pole of creative power.
2. K'un (☷), the receptive, earth, is associated with the womb, nourishment, the great wagon of the earth that carries all life. It represents the pole of yielding, docile receptivity.
3. Chen (☳), the arousing, thunder. It is associated with movement, speed, expansion, and anger. In terms of human polarities, the sign represents confrontation.
4. Sun (☴), the gentle, penetrating wind. It is associated with gentle persuasion, quiet decision making, and problem solving. The sign represents the pole of support.
5. K'an (☵), the abysmal, water. It is associated with toil, hard work, danger, perseverance, and melancholy. It represents the pole of body and feeling.
6. Li (☲), the clinging, fire. It is associated with dependency, but also with clarity and perception. It represents the pole of intellect and thought.
7. Ken (☶), keeping still, the mountain. It is associated with fidelity, meditation, watchfulness. It represents the pole of reflective silence.
8. T'ui (☱), the joyous, lake. The sign is associated with the pleasures of the mouth —eating, talking, singing. It represents the pole of joyful interaction.

The eight pa kua are arranged in a circle of polar opposites known as the "primal arrangement," or the "mandala of earlier heaven." (See Figure 1.)

Implications for a Theory of Group Process

The philosophy of *Tao* and the forces of yin and yang as presented in the *I Ching* have implications for a theory of group process.

1. The group can be viewed as an energy field demarcated by the basic polarities, as in Figure 1. In each member, and in the group as a whole, there is tension between the apparent choices of creative-receptive, confrontation-support, intellect-feeling, and interaction-silence.

2. Initially, group members attempt to deal with their process by adhering to polar positions. This is an attempt to "freeze" movement, deny change, or place values on the respective polar opposites.

3. Group process proceeds as the group develops awareness of its polarized situation. This awareness leads to a struggle to find creative ways to resolve the interplay of yin and yang forces. Paradoxically, this creative struggle develops two new aspects of group life: the appreciation of the now, and the potential to transcend the polarized field of apparent opposites.

4. The group process is analogous to a roller-coaster ride (Kahn et al., 1974). Energy waxes and wanes; it never stops. The process goes up and down; moments of group life are different from

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one another, but not better or worse, immature or more mature. As Kalin et al. (1974) suggest, "at any given moment things are as good and important and worth attending to as they are ever going to be. [The model] urges us to attend to the here-and-now because no future here-and-now is going to be any better, just different" (pp. 43-44). Focus on the now (now-consciousness) is the dynamic unification of past and future in the present moment (Dhiegh, 1974).

5. The group members, by focusing on the now, begin to test synergistic strategies to deal with the apparent polar opposites. Synergy, as defined by Hampden-Turner (1970), refers to "a state of mutual enhancement" between two opposites, an affective and intellectual synthesis that is greater than the sum of its parts.

Synergy allows the group and its members to free themselves from either/or thinking. Synergy is neither compromise nor striving for a "golden mean"; it is a creative combination (conception of a human being from egg and sperm is the highest form of synergy) of opposites to produce something new. Synergy, in the words of Harris (1972), involves grasping a paradox and holding it in creative tension.

6. Groups are unique and idiosyncratic. Each group presents opportunities for growth. Polarities, which are critical issues for some groups or some group members, are nonissues for others. Resolutions or synergistic combinations of polarities will vary from person to person, from group to group.

The cycle of group process follows this course: (1) a struggle to deny change by clinging to polarities, resolved by (2) appreciation of the now and the discovery of the governing principle of change, allowing (3) attempts at synergy to transcend or mutually enhance the polar opposites, followed by (4) the product of the synergy becoming a new pole, awaiting a new struggle to "freeze" change, thereby completing the cycle. The cycle is a dialectic process, subtly changing while remaining much the same.

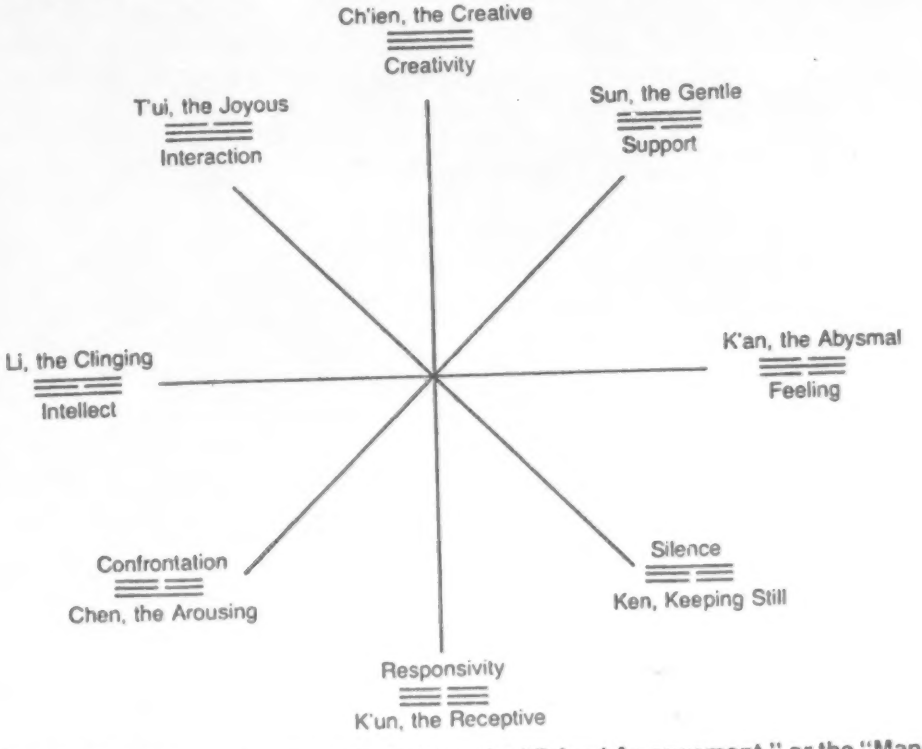

Figure 1. The *Pa Kua* Arranged as Basic Polarities, the "Primal Arrangement," or the "Mandala of Earlier Heaven"

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Characteristics of the Cyclical Model

The intervention stance of the cyclical model focuses on individual-member elements. The major strategy is to amplify minute physical or verbal events so that an appreciation of now and an awareness of polarity can occur. It focuses on the individual's cycle of "becoming, begetting, begoning" (Dhiegh, 1974); as in a theater, only one member or a small cluster of members "perform" at a given time.

The model links human events with other natural phenomena and teaches the ancient philosophy of *Tao*, which aims for personal centeredness and integrity in a world of turmoil and conflict. Central to the cyclical model derived from *I Ching* is the idea that man is in the center of events: it is the individual's responsibility to know the direction of cosmic change and to move in the direction of change, not against it (H. Wilhelm, 1960). The intervention stance reflects this: the group leader provides a constant focus on the individual's responsibility to "own" his change process.

Discussion of the cyclical model of change can be found in Dhiegh (1973, 1974), Fuller (1975), Kahn et al. (1974), and H. Wilhelm (1960). Personality-development theories that imply a cyclical model of change are presented by Allport (1955), Hampden-Turner (1971), and Polster and Polster (1973).

TOWARD INTEGRATION

Cardinal aspects of the three models of change are summarized in Table 1. The models and theories that contain them are attempts to understand what happens in human groups. The observational bases of the models differ. (The table provides an illustration of the old Sufi story of the blind men and the elephant. Each man touched a different part of the beast and concluded that the elephant was like a rug, or a hose, or a pillar.) Questions arise: Can there be one theory of group process? Is integration possible? How can the group practitioner use this abundance of theoretical formulation?

As one option, an integrated theory would offer several benefits. Reducing the profusion of terms would heighten conceptual clarity; a comprehensive view would enable a group to capitalize on all or most of the data it produces. Sharing of techniques derived from different theories would broaden and enrich the practitioner's intervention repertoire.

Some solid attempts at integration have been made. Schutz, although espousing a linear model, has incorporated some cyclical aspects in his interpersonal-needs approach: as a group concludes its movement through stages of inclusion, control, and affection, it recycles and begins working the same issues, but on a different level of intensity and meaning (Schutz, 1973). Kaplan and Roman (1963) postulate that a helical regression occurs before a group enters its linear phases of dependency, power, and intimacy. Bennis and Shepherd (1956) employ a synergistic union of polarities in their initial authority-relations phase, in which dependence and counterdependence themes collide, to be resolved by the emergence of an independence theme. Butkovich and his associates (1975) report a combination of approaches derived from the linear and helical models to understand T-groups and Tavistock groups.

These partial integrations have proved useful in group work, providing insights for the understanding of group phenomena. They do not account sufficiently for the influence of the individual on the group process. Linear and helical models deal primarily with the group; the cyclical model, with the individual. That hybrid creature, the individual-in-the-group, provides the central dilemma for an integrated model.

Eclecticism, a time-honored system in the practical arts, provides another option. Most of us live with a pastiche of conflicting viewpoints and choose, as the situation demands, the one that seems most useful at the moment. We may believe, on an intellectual level, that a chair is a moving collection of molecules, but we expect it to be solid when we sit down. Alas, the theory that simultaneously meets the needs of our head and our behind is a rarity indeed.

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Table 1. A Summary of the Characteristics of the Linear, Helical, and Cyclical Models of Change

	GROUP MODEL		
Characteristic	**Linear**	**Helical**	**Cyclical**
Group Movement	Progressive	Regressive	Cyclical
Group Metaphor	Community	Tribe	Theater
Time Focus	Future	Past	Now
Goal	Completion	Corrective Emotional Experience	Synergy
Tension Source	Desire to Improve	Desire to Understand	Desire to Transcend
Intervention Focus	Group Elements	Contextual Elements	Individual Elements
Observation Base	Interpersonal	Historical	Intrapersonal
Representative Theory	Schutz	Bion	*I Ching*
Personality Theory Correlated with Model	Erickson	Freud	Hampden-Turner
Strength	Easy to Understand	Comprehensive	Nature-Based
Drawback	Static	Dependency on Group Leader	Paradoxical
Usual Application	Encounter Groups, Task Groups, Social Systems	Many Psychotherapy Groups	Gestalt Groups, Personal Growth Groups

Eclecticism permits the practitioner to respond to a critical incident in the group by reviewing the objectives of the group and the needs of the members and then selecting the intervention from a theory base that seems most productive for learning. The eclectic stance permits the practitioner to shape his own theory and allows the leader to be present both as a person and a role.

A possible, unfortunate side effect of an eclectic approach is a choppy, uneven flow in the group process. Groups seen through a Tavistock viewpoint in one session, a Gestalt in a second, and an interpersonal-needs theory in the third session can become confused and unproductive.

Scaffold for an Integrated Theory

The following propositions sketch the elements of an integrated model and constitute a first attempt to collate the salient features of several theories. The propositions have as a data base the author's observations of phenomena in psychotherapy, growth, and task groups, as well as the observations and findings of other investigators of group behavior.

The integrated model posits a series of dialectic confrontations, which occur within group members and within the group as a whole. The dialectic consists of interplay between the constructs of yin and yang, viewed as energies in polar opposition to the potential for synergistic

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fusion.[1] The series of polar confrontations occurs within phases, similar to those described by Tuckman (1965) as "forming, storming, norming, performing." These phases repeat themselves, in a spiraling fashion, until some degree of wholeness or integration is reached, or until the group artificially terminates or abandons its task.

The ancient Chinese scripture *The Secret of the Golden Flower* (R. Wilhelm, 1962) describes a similar intrapersonal dialectic as an individual moves toward enlightenment. This text and Jung's commentary detail a circular movement in which the union of opposites occurs repeatedly until a higher state of consciousness is reached. The cyclical movement continues until all disparate body and human events are integrated (by transcendence or death) into the oneness of *Tao*.[2]

In this integrated model, the confrontation of polarities occurring within individuals is seen as impacting the group constellation as well. The group is not only a theater in which individuals struggle to deal with change; it is also an event in itself that develops and attempts to integrate its energy sources.

The group, as its etymology indicates, is a knot composed of many threads, stronger and more complex than its components.

Appended to the group-process propositions are references to *I Ching kua* that illuminate the dynamics of a particular phase. The *I Ching* serves remarkably well as a guidebook for both the group leader and the group members as they collectively pursue their task. The richness of the *I Ching*'s wisdom applied to group work can only be suggested here, but the text of the eighth *kua*, "Holding Together," may serve to illustrate the advice it offers for beginning groups.

> 8. Pi: Holding Together (Union)
> *The Judgment*
> Holding together brings good fortune
> Inquire of the oracle once again
> Whether you possess sublimity
> constancy and perseverance;
> Then there is no blame.
> Those who are uncertain gradually join.
> Whoever comes too late
> Meets with misfortune.
>
> What is required is that we unite with others, in order that all may complement and aid one another through holding together. But such holding together calls for a central figure around whom other persons may unite. To become a center of influence holding people together is a grave matter and fraught with grave responsibility. It requires greatness of spirit, consistency and strength. Therefore, let him who wishes to gather others about him ask himself whether he is equal to the undertaking, for anyone attempting the task without a real calling for it only makes confusion worse than if no union at all had taken place.
>
> But when there is a real rallying point, those who at first are hesitant or uncertain gradually come in of their own accord. Late-comers must suffer the consequences, for in holding together the question of the right time is also important. Relationships are formed and firmly established according to definite inner laws. Common experiences strengthen these ties, and he who comes too late to share in these basic experiences must suffer for it. (R. Wilhelm, 1950, p. 36)

Basic Premises of an Integrated Theory

Following are the premises on which this integrated theory is based.

1. Change happens naturally. Change is the interplay of yin and yang energy and not the result of frustration, conflict, disequilibrium, or a search for homeostasis; change simply is.

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[1]The term "contrapletion," which expresses both the polar opposition and the capacity of the poles to complement or fulfill each other, can be used to describe the yin/yang relationship.

[2]A Western description of polar opposites that define certain personality types can be found in the poet Yeats's *A Vision* (1956). For a brilliant discussion of polar forces operating in society and history, see Thompson's *At the Edge of History* (1972).

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2. The group provides a setting for focused and accelerated change. Groups exist to facilitate, intensify, and enrich the change process.
3. The primary task of any group is to respond creatively to change.
4. The energy of individual members and of the group is distributed as yin and yang forces.
   a. *Yin* forces take the form of passivity, docility, receptivity, and simplicity. The yin posture of individuals and of groups is one of waiting to be acted upon, yielding, and accepting.
   b. *Yang* forces take the form of activity, creativity, excitement, and firmness. The yang posture of individuals and groups is one of acting, confronting, and inviting.
5. Every group presents a unique constellation of yin and yang forces, a composite contributed by all group members, including the leader.

Propositions Regarding Group Process

The kaleidoscope provides an image of group process. As yin/yang forces begin to interface, they move subtly and delicately, providing a constant movement through phases. The phases, or movements, are named for appropriate hexagrams from the *I Ching;* each is demarcated by the basic polarities of the mandala of earlier heaven. (See Figure 1.) The sets of polar opposites "govern" a given movement: that is, a given set epitomizes the polar opposition of a given movement.

Initial Movement: *Gathering Together*

The movement is governed by the creative/receptive polarity. The group perceives yang forces residing in the group leader, yin forces residing within itself. The group acclimates itself to its setting; feelings involved are excitement, apprehension, and confusion. The immediate task for the group is developing an awareness and appreciation of the collective situation.

This initial period finds representation in most theories of group development. It involves a basic orientation toward the group situation, a settling in. Major issues revolve around defining self, defining the task, and defining the function of the group and the leader. The movement concludes when there is general agreement that change is in fact possible in the group, whether it is changing behavior, making a decision, or solving a problem.

Kua that illuminate this phase include the following: 1. The Creative; 2. The Receptive; 3. Difficulty at the Beginning; 8. Holding Together; 10. Conduct; 17. Following; 31. Influence; 42. Increase; 45. Gathering Together; and 48. The Well.

Second Movement: *Standstill*

The movement is governed by the thinking/feeling polarity. The awareness of the possibility of change, begun in the initial phase, is now met by a denial of the possibility of and need for change. Group members adhere to one or another polar opposite, dichotomize their options, and develop an either/or mentality. Splits between thinking and feeling, between body and mind are fixated. The feeling level is marked by a clinging dependency on old ways and a resistance to accept the dangers that work and change involve.

This polarizing effect of early group interaction is documented in the work of Myers and Lamm (1975). After some initial effort to alter previously held positions, group members revert to their previous, pre-group stance and fight to maintain it. This phenomenon, variously described as regression or resistance, seems to occur when the group is perceived as an arena wherein bedrock values, beliefs, and worldviews can be challenged.

In the standstill phase occur many of the regressive phenomena described by Bion as the "basic-assumption" group. The movement is marked by tension and working; it begins to change

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into the following movement when an issue that is of magnitude and moment for most group members emerges.

Kua associated with this phase are the following: 6. Conflict; 12. Standstill; 13. Fellowship with Men; 19. Approach; 29. The Abysmal; 30. The Clinging, Fire; 35. Progress; 44. Coming to Meet; 46. Pushing Upward; and 49. Revolution.

Third Movement: *Biting Through*

The kaleidoscope continues. The third movement is governed by the confrontation/support polarity. Group members develop a greater awareness of possibilities for change. There is a heightened arousal of feeling and a greater need for nourishment. Letting go of polar positions releases power and energy, motivating the group to attempt to grasp the paradox that mutual enhancement of apparent opposites can occur. The group struggles to redistribute yin/yang forces; members impact the leader; the leader impacts the group.

This movement is marked by the emergence of a "both/and" attitude, which replaces "either/or" thinking. Power and authority are seen as residing both in the group and in its members. It is the central period in many theories of group development. When the smoke clears and new learnings (insights, solutions) are apparent, the movement concludes and enters the fourth period.

Kua that illuminate this phase are the following: 6. Conflict; 16. Enthusiasm; 21. Biting Through; 23. Splitting Apart; 33. Retreat; 38. Opposition; 34. Obstruction; 41. Decrease; 51. The Arousing; 57. The Gentle; and 28. Preponderance of the Great.

Fourth Movement: *The Taming Power of the Great*

The movement is governed by the interaction/silence polarity. The group creatively achieves a degree of synergistic fusion. The feelings are focused on enjoyment of the new and the now. Reflective, meditative, incorporative silence coexists with playful and pleasurable interaction with others. The task seems completed; needs are for closure, repose, quiet.

This movement is marked by integration and celebration. Much work is accomplished; previously difficult issues are simply and easily resolved. There are attempts to "freeze" change; a group may end its work here. As it develops awareness that its apparent terminal point also offers the possibility for a new beginning, the group fades into its fifth movement.

Kua associated with this phase are the following: 11. Peace; 20. Contemplation; 26. The Taming of the Great; 27. Nourishment; 32. Duration; 37. The Family; 40. Deliverance; 50. The Caldron; 52. Keeping Still; 58. The Joyous; 61. Inner Truth; and 63. After Completion.

Fifth Movement: *Return*

The circulation is finished, temporarily; the group is at a new starting point. The kaleidoscope is rearranged; new polarities, the recently gained synergistic fusions, provide a field for new beginnings and greater closeness to *Tao*. The cycle spirals onward.

Kua associated with this phase are the following: 24. Return; 34. The Power of the Great; 43. Breakthrough; 49. Dispersion; and 64. Before Completion.

CONCLUSION

This theory is presented to be studied, tested, and then thrown away. As Kahn and his colleagues (1974) observe, theory itself is part of the flow of change: "Even as we grasp it and write it down, it becomes inadequate, melting away" (p. 51).

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money. The first was a Persian, who said, "I will use the money to buy *Angur*." The second was an Arab, who said, "No, because I want *Inab*." The third was a Turk, who said, "I do not want *Inab*, I want *Uzum*." The fourth was a Greek. He said, "I want *Stafil*." Because these four had information but no knowledge, they started to fight.

One person of wisdom present could have reconciled them all by saying, "I can fulfill the needs of all of you, with one and the same piece of money. If you honestly give me your trust, your one coin will become as four, and four at odds will become as one united."

Such a person would know that each in his own language wanted the same thing: grapes.

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INTRODUCTION TO THE STRUCTURED EXPERIENCES SECTION

In publishing these structured experiences, we assume that facilitators are natural innovators. They gather ideas or suggestions from many sources, but they usually adapt, restructure, redesign, supplement, or otherwise vary the materials they collect. Since structured experiences are almost infinite in their possible variations, they can easily be adapted to suit the needs of a particular group, the goals of a training design, or the special capabilities of the facilitator using them.

The structured experiences in this volume of the *Annual*—designed to focus on individual behavior, constructive feedback, group processing, and psychological integration—will, we hope, trigger other ideas, developments, expansions, and transformations. The variations listed for experiences are intended to suggest to users some such creative adaptations.

Cross-references to similar and complementary structured experiences and suggestions of appropriate lecturettes and other materials in the University Associates Series in Human Relations Training are listed at the end of individual structured experiences.

Since one new structured experience seems inevitably to suggest yet another, we announce the planned publication in 1975 of Volume V of *A Handbook of Structured Experiences for Human Relations Training*. Following the format of Volumes I, II, III, and IV, Volume V will offer additional valuable resources to the group facilitator.

As in previous *Annuals* and in our *Handbooks*, we have arranged the structured experiences in the *1975 Annual* in order of the degree of understanding, skill, and experience required by the facilitator. The expertise of individual facilitators varies, and the first structured experiences generate less affect and data than do later ones, thus demanding of the facilitator less background to use them effectively and responsibly.

The skill of the facilitator becomes especially crucial in the processing of the experience. If the structured experience is to be responsive to the needs of the participants, it must be adequately processed so that the participants are able to integrate their learning. Stress can result from inadequate discussion of reactions to the activity. This processing must be the responsibility of the facilitator. Therefore, he should select a particular activity on the basis of two criteria: his own competence and the needs of the participants.

Sharing is our aim. Thousands of facilitators use structured experiences that we have published, and we are glad that they agree with our philosophy that sharing is in the true spirit of human relations practice.

AN EXPERIENTIAL MODEL

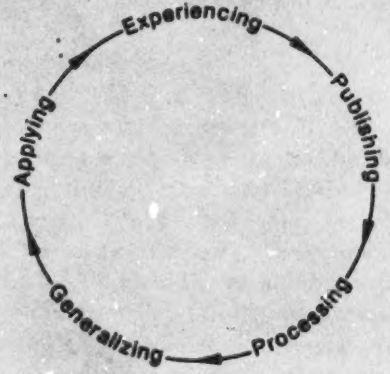
The structured experiences in this volume are designed to implement an experiential model. The model is based on a cyclical learning process of five separate but interlocking procedures. As implied by the name of the model, the emphasis is on the *direct* experiences of the participant or learner—as opposed to the *vicarious* experiences garnered through didactic approaches.

The experiential model is also an *inductive* rather than a *deductive* process: The participant *discovers* for himself the learnings offered by the experiential process. His discovery may be facilitated by a leader, but, in the end, the participant finds and validates his own experience.

This is the "laboratory"—or experimental—approach to learning. It is based on the premise that experience precedes learning and that the learning, or meaning, to be derived from any experience comes from the learner himself. Any individual's experience is unique to himself; no one can tell him what he is to learn, or gain, from any activity. Probable learnings can, of course, be

devised, but it us up to the participant to validate these for himself.

Five revolving steps are included in the experiential model.



Experiencing

The process usually starts with experiencing. The participant becomes involved in an activity; he *acts* or *behaves* in some way or he *does, performs, observes, sees, says* something. This initial experience is the basis for the entire process.

Publishing

Following the experience itself, it becomes important for the participant to share or "publish" his reactions and observations with others who have either experienced or observed the same activity.

Processing

Sharing one's reactions is only the first step. An essential—and often neglected—part of the cycle is the necessary integration of this sharing. The dynamics that emerged in the activity are explored, discussed, and evaluated (processed) with other participants.

Generalizing

Flowing logically from the processing step is the need to develop principles or extract generalizations from the experience. Stating learnings in this way can help participants further define, clarify, and elaborate them.

Applying

The final step in the cycle is to plan applications of the principles derived from the experience. The experiential process is not complete until a new learning or discovery is used and tested behaviorally. This is the "experimental" part of the experiential model. Applying, of course, becomes an experience in itself, and with new experience, the cycle begins again.

FAILURE OF STRUCTURED EXPERIENCES

Structured experiences can "fail." That is, they may not produce the predicted results, or they may produce unexpected results.

Usually, such failure occurs when the experiential model outlined is truncated or abbreviated or when it is inadequately implemented. Each step in the model is an essential part of the entire sequence; each needs sufficient attention to effect its full impact. As stated previously, inadequate processing is the most common cause of the failure of the model.

Unfortunately, failure on the part of any facilitator only increases the chances that other facilitators may encounter difficulty in their attempts to present a structured experience. If participants in a learning activity have previously had ineffective training experiences, it is likely that they will be more resistant to, and less inclined to involve themselves in, such experiences in the future.

Thus, the question of the "failure" of structured experiences becomes significant. Failure promotes subsequent failure. For this reason, we are stressing here the need for facilitators to confront the demands and requirements of the experiential model so that they—and their colleagues who follow them—may gather the rewards and benefits the model offers.

The implications of the model stress the necessity for adequate planning and sufficient time for each step. An appropriate structure is especially important for processing, generalizing, and applying. When handled with care, concern, and skill, the experiential approach is invaluable for group facilitators in the human relations training field.

CATEGORIES OF STRUCTURED EXPERIENCES

Categorizing structured experiences becomes somewhat arbitrary, since, as we have indicated,

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each experience can often be adapted for a variety of training purposes.

All structured experiences published in our Series in Human Relations Training—the *Annuals* and *Handbooks*—are numbered consecutively. Including the *1975 Annual*, we have now published 148 structured experiences.

The following chart includes, in abbreviated form, the titles of all our published structured experiences. Each activity is classified according to its most common use. Each item is listed only once, although any given experience could conceivably be used for several different purposes or activities. For easy location of a particular structured experience, its number, volume, and page number are given.

A Reference Guide

In order to offer a more complete, convenient means of reference for users of our experiences, we have developed a booklet, *Structured Experiences for Human Relations Training: A Reference Guide*, that offers categorizations of all structured experiences by number, by category, and by title. Thus, the experience appropriate for a particular need can be located quickly and easily. The entry for each structured experience includes the number, title, goals, group size, time required, and volume and page number of the published experience. Our readers are invited to write us for a complimentary copy of this valuable and useful *Reference Guide*.

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STUDY GUIDE AND WORKBOOK

3ALR73430B/3OLR7361B/3OZR7364B-III-6-9

Technical Training

Drug and Alcohol Abuse Control

GROUP FACILITATION
(DECISIONMAKING PROCESS)

April 1977

3250TH TECHNICAL TRAINING WING
3290TH Technical Training Group
Lackland Air Force Base, Texas

Designed For ATC Course Use

DO NOT USE ON THE JOB

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Social Actions Training Branch
Lackland AFB, Texas

SW 3ALR73430B/3OLR7361B/
3OZR7364B—III-6-9
April 1977

GROUP FACILITATION
(DECISIONMAKING PROCESS)

OBJECTIVE

Identify six decisionmaking processes and the consequences which can occur from the use of these processes.

INTRODUCTION

A major concern, probably one of the more important issues in interpersonal, group, and organizational functioning, is: "How are decisions made?" This question is sometimes overlooked in our various groups that we are involved in, such as the small group that you are in now, the staff working group back at your office, or your Drug/Alcohol Abuse Control Committee (DAACC) at your base. Many of us are prone to focus on the big decision and ignore or not even be observant of the minor decisions which, in effect, have more immediate impact on our lives.

There are many different ways to make decisions in a group. Whether one decision-making process is better than another is a complex question. It is important that we do not judge too quickly the appropriateness and effectiveness of our decisionmaking procedures. One decisionmaking style may not be best for all situations. More important is that we recognize that groups make decisions and that there are particular consequences depending on the particular decisionmaking process.

INFORMATION

DECISIONMAKING PROCESS

Appropriateness of a Decisionmaking Process

Before looking into the various decisionmaking processes, let us consider some of the factors that affect the appropriateness of any decision:

TIME AVAILABLE. The amount of time available in which to make the decision; e.g., deciding whether or not to jump out of a burning aircraft versus deciding whether or not to design a new weapon system.

GROUP HISTORY. The past history of the group; e.g., what are the rules for the group and how do I get those rules to work for me?

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KIND OF TASK. The type of task is important in choosing an appropriate decision-making process. Sometimes having a qualified individual make decisions is best if the task requires precise judgement or hasty action; e.g., battlefield situations, survival procedures, aircraft malfunctions, fires, etc. Consensus may be better for determining long-range goals, deciding meeting times or places, etc.

CLIMATE DESIRED. The kind of climate the group wants to establish, e.g., permissive, trusting, competitive.

Decisions and Consequences

LACK OF RESPONSE. The floors of most group meetings are completely covered with "plops." Plops are suggestions that no one seconds or "takes up" in agreement. This is the most ineffective group decisionmaking process. All ideas which have been bypassed (to which no member has responded) result in a common decision not to support them. This decision-making process may result from several fears including the following: fear that others will disapprove of a group member's support; fear of being "trampled" by group members who are critical; fear that, if one agrees with the idea, the suggester will dish out so much work that the group will be overwhelmed with work.

AUTHORITY RULE. All determination of policy is made by the leader. Techniques in authority rule in activity steps are dictated by the authority, one at a time, so that future steps will always be uncertain to a large degree. The leader usually dictated the particular worktasks and work companion(s) of each member. The dominating leader tends to be personal in his/her praise or criticism of each member's work and aloof from group participation except when demonstrating. This type of decisionmaking process is highly efficient (fast), but sometimes ineffective due to the minimum amount of group involvement.

MINORITY. Decision by minority is a self-authorized decision (by chairperson or any other member of the group). The minority decisionmaker may offer suggestions and then shift immediately into action before any other alternative can be considered. This kind of decision may be signified by a "hand clasp." A *"hand clasp"* occurs when two members of the group simultaneously support an idea, and their enthusiasm overwhelms the group. A *coalition* occurs when several group members support and push through their suggestions. If no other viable solutions are offered, or if other members remain silent, then the coalition's suggestion dominates.

MAJORITY RULE. Decision by majority rule is usually accomplished by voting and/or polling. This is the "democratic" method, and everyone is encouraged to participate. The consequences of this type of decisionmaking are that sometimes "win-lose" situations are created; this may later affect the implementation of the decision. The minority may feel insufficient time was given for the discussion and decide that, next time, "we'll win!"

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CONSENSUS. Decision by consensus is one of the most effective, but most time-consuming, decisionmaking processes. Consensus is not unanimity, but a situation wherein everyone in the group feels that he/she has had a fair chance to influence the decision. Members who do not take the majority alternative understand it clearly and are prepared to support it. A lot of time is needed for all members to state their oppositions and to allow careful listening by others to understand minority alternatives.

Certainly, this time-consuming procedure will not be applicable to all group decisions.

UNANIMOUS CONSENT. Decision by unanimous consent is perfect but rarely achievable. It is not always necessary and is probably highly inefficient. Groups that want to make decisions in this manner may be setting too high of a standard for themselves.

EXERCISE

Complete the following exercise.

1. What four items must be considered for any decisionmaking process?

2. What is probably the most ineffective decisionmaking procedure.

3. Which decisionmaking procedure has the least amount of group involvement?

4. A "hand clasp" is indicative of which decisionmaking procedure?

5. Which decisionmaking procedure is considered to be "democratic"?

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6. What is the most effective decisionmaking procedure?

7. Which decisionmaking procedure is rarely achievable?

SUMMARY

In this unit we discussed factors to consider when making decisions. These were: time available, past history of group, task being discussed, and kind of group climate. We also covered the six decisionmaking processes and the consequences of using each of them; lack of response—ineffective; authority rule — minimum involvement; minority rule—lack of total support; majority rule—creates win-lose situation; consensus—time consuming; and unanimous consent—rarely achievable.

Understanding the decisionmaking process being used in a group may stimulate involvement and a desire for group members to return. Insuring the group decisionmaking process is known to all members could be the difference between a successful and an unsuccessful group. How are the decisions made in your DAACC, Rehabilitation Committee, office, or staff working committees?

ANSWERS TO EXERCISE

1. Time available, past history of group, kind of task being discussed, and group climate desired.
2. Lack of response.
3. Authority.
4. Minority.
5. Majority rule.
6. Consensus.
7. Unanimous consent.

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STUDY GUIDE AND WORKBOOK

3ALR73430B/3OLR7361B/3OZR73648-VI-1-3

Technical Training

Drug and Alcohol Abuse Control

GROUP FACILITATION – GROUP COUNSELING

15 August 1978

USAF TECHNICAL TRAINING SCHOOL
Lackland Air Force Base, Texas

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Designed For ATC Course Use

DO NOT USE ON THE JOB

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Social Actions Training Branch
Lackland Air Force Base, Texas

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3O%R7364B-VI-1-3
15 August 1978

GROUP FACILITATION – GROUP COUNSELING

BEHAVIORS CLIENTS NEED TO LEARN

OBJECTIVE

Identify basic group counseling techniques.

INTRODUCTION

The most effective way to counsel drug/alcohol clients, with few exceptions, is group counseling.

INFORMATION

Research indicates that one reason that clients change is that they learn to be clients. They learn the rules for being a "good" client. There is a certain interesting, challenging, gamelike aspect to counseling that promotes rapid learning. In behavior modification terms this is called stimulus generalization. People react in a particular way in certain situations, and in other similar situations they tend to react in much the same fashion. This is especially true if members of the group role-play typical situations that occur outside the group and work out a variety of solutions. An example of when stimulus generalization may be effective is an Al Anon group role-playing typical domestic situations, then taking the new methods of solving problems back home and using them.

SEPARATE THOUGHTS AND FEELINGS

Learning to separate thoughts and feelings is a skill that can be taught in a relatively brief amount of time with long-lasting results. Our culture has given emotions almost a magical power. We speak of "I fell in love." or "He made me mad." as if those emotions jumped out of trees, grabbed us, and made us powerless before them. The reality is that we can learn to have as much control or choice over emotions as other areas in our lives. The basis for gaining that control is to distinguish thoughts from feelings. Example: "I think that . . ." instead of "I feel that . . . ."

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GIVE AND RECEIVE FEEDBACK

As people give feedback they learn to ask for what they want behaviorally and specifically. This is an important skill for getting what we want in life. Giving and receiving feedback in an appropriate manner can help employer/employee relationships, marriages, and other social settings. Giving and receiving feedback is a simple concept that clients often have a difficult time applying. As the social situation becomes more potentially risky, the client will hesitate and show great reluctance to proceed. Reteaching will be necessary in order to break old, partially-effective habits and learn new, more effective ones. One side-benefit of learning to receive feedback is that doing so requires the client to carefully listen to others. This listening, without preparing defenses, enables the client to pay more attention to the environment and read the environment's possibilities correctly. This enables the client to make better decisions about living.

STAY IN THE HERE AND NOW

As clients stay in the "here and now" their needs begin to emerge. By being more aware of their needs, clients are now more capable of fulfilling those needs. Instead of living with lots of unfulfilled, energy-draining needs, clients work on getting what they need. It's like talking to someone interesting while needing to go to the bathroom. Trying to stay and listen, with your legs crossed, is not as effective as saying: "I'm having a hard time listening when I have to go to the bathroom so badly. Will you excuse me for a minute so I can really focus on what you're saying?"

"Why" questions are generally an invitation to leave the "here and now" and go into the past. For example: "Why can't you be close to people?" The client's response is a long explanation and possible defense to include the onset of the problem during bad toilet training. "Now, what can you do about your bad toilet training?" Very little!

Instead of "why" questions, use "what," "how," and "when" questions. For example: The question "Why are you in this marriage that you say is so destructive to you?" could be rephrased to "How does staying in this marriage serve you in some way?" or "What brings you to counseling now—not last year or next year? What is happening now?" These questions are more immediately focused and consequently likely to elicit usable information.

OWNING OR TAKING RESPONSIBILITY FOR THOUGHTS AND FEELINGS

Owning thoughts and feelings has a number of benefits. First, making "I" statements increases the impact of the statement while giving it a greater intensity. Second, when statements are owned, the client begins to have thoughts of power over those statements in order to make them come true or false. For example: "You can't tell people what you think." differs in quality from "I can't tell people what I think." when followed by a counselor question of "You can't or you won't tell people what you think?" The client responds with "I guess I won't tell people what I think." This is a whole new ball game from "You can't tell people what you think."

EXERCISE I

Complete the following exercise.

1. How can counselors keep the group members in the "here and now"?

2. When do clients start asking for what they want?

3. How can clients increase the impact of their statements?

4. How can clients gain control over their emotions?

FACILITATOR INTERVENTIONS

Facilitators need to be aware of the following statements in order to make interventions that will promote growth.

Knowing when to make interventions is a skill worthy of learning. Group members begin to integrate their learning of concepts as well as the practical application of them. Interventions are a means of keeping the group member's thought processes locked on "target." The basic issue

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of short-term rehabilitation is the acceptance of individual responsibility by the client. Who in the client's life is going to be responsible for the client's behavior? Hopefully, the client. Often, clients are playing "If it weren't for you, I'd be okay." which translates to "If it weren't for me, I'd be okay." The real issue is "What do the clients want, and are they willing to pay the price to get it?"

SOMEONE ELSE MUST CHANGE IN ORDER TO SOLVE MY PROBLEM

Facilitators make an intervention when a group member says or implies, "Someone else must change in order to solve my problem." For example: "If the Air Force would just change the rules about marijuana, I'd be okay." An intervention for this might be: "Sounds to me like you're planning on getting kicked out of the Air Force. Since the Air Force doesn't seem to be changing the rules, you seem to be making a decision to leave." Intervene in situations like this by letting the client know he/she is really making a decision about his/her life.

STATEMENT DESIGNED TO PERPETUATE THE PAST

Facilitators will also want to make an intervention when a client makes a statement designed to perpetuate the past. For example: "I've always been like this." An intervention to make might be, "I hear you saying you are helpless." Let the client know that he/she is being a slave to tradition, and that the client can choose to be different.

EXERCISE II

Complete the following exercise.

1. When do facilitators make interventions in relation to client statements?

2. What would be an example of a statement designed to perpetuate the past?

3. What would be an example of a statement requiring someone else must change in order to solve members' problems?

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INVITATIONAL COUNSELING

These principles of counseling will enable clients to be more responsible for their own growth.

The principle of invitational counseling states that:

COUNSELORS CAN'T MAKE CLIENTS DO THINGS

What are you going to do, give clients a direct order to be responsible, or threaten them, like "If you don't quit grass, I'll write your mother"? It is best for counselors to remember that counselors can't really make clients do things they don't want to do; forcing can encourage half-hearted trying.

INVITE RESPONSIBILITY

Counselors can invite clients to responsibility and taking better care of themselves. It is the difference between saying "If you don't come out, I'll burn the house and break down the door." and "Hey! Can Bob come out and play? It could be scarey, but we're going to have a good time."

BUILD ON STRENGTHS

Invite responsibility by building on strengths. Stroke group members for what is wanted and look for their strengths. You can't build on weakness, but you can build on strengths. Example: "That was a risky step you took just now -- telling me to get off your back."

INVITE SELFISHNESS

This concept is simply the "child to child" contract with "parental" approval. The best method for achieving this is to ask, "What would you like to get for you out of being here?" Instruct clients to be as selfish as they dare. "Would you be willing to not let others get power over your life?" Clients should not be expected to give something up unless they have something better to replace it with.

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EXERCISE III

Complete the following exercise.

1. What is the principle of invitational counseling?

2. What does it mean to invite responsibility?

3. How can counselors build on strengths?

4. How can counselors invite clients to be selfish?

QUESTIONS BEFORE STARTING A GROUP

These questions will increase group effectiveness by encouraging planning.

What you do in opening a group sets behaviors that can influence the rest of the group's interactions; therefore, careful planning is desired, if not mandatory. To plan carefully, ask yourself the following questions:

WHAT IS THE PURPOSE OF THE GROUP?

Am I having a group because somebody said so, or do I have clients that can be helped by being in groups? What are my hopes for this particular group—the "why have it" question?

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HOW DO I WANT THE GROUP'S PURPOSE TO HAPPEN?

What is my game plan—Transactional Analysis, Gestalt, Rogerian, Values Clarification, or all of the above? How do I want the group to meet its objective? Basically, this step involves making some predictions regarding outcomes. Where will the group be at any given time?

HOW CAN I GIVE THAT MESSAGE BOTH OVERTLY AND COVERTLY?

I must be congruent. If I begin the group by inviting people to take responsibility for themselves, and then beg them not to leave the group, these messages aren't congruent. Counselors must make sure they are consistent in what they say and what they do, and what they say and do combined communicates what they want.

HOW WILL I INVITE CLIENTS TO TAKE RESPONSIBILITY FOR THEMSELVES?

Counselors should ask themselves, "What messages do I give?" and "What messages shall I be sure not to give?" Then it is real important to assess the impact of what you say on the total group atmosphere. For example, one message I might give is, "This is your chance to work on you; please be as generous with yourself as you dare." A message I may want to be sure not to give is, "We have complete confidentiality here."

EXERCISE IV

Complete the following exercise.

1. When do counselors ask themselves the "why have it" question?

2. What is the purpose of deciding on a game plan?

3. How do counselors invite clients to take responsibility for themselves?

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CLOSURE

Closure is not magical and doesn't come about at a certain time. Closure is a process that occurs throughout the group instruction.

Closure is just as important as opening a group. Careful planning is essential in order to leave the members in a good place upon closing the group. Group Closure is not one single item that occurs at a given time; rather it is an ongoing process. There is a covert message to counselor/client relationships which is "We get to see each other as long as one of us is sick." Closure, then, is a subtle invitation to get sick (have problems) so we can keep the relationship going. Studies show an increase of client problems just before or after termination of counseling for just this reason. Closure can be facilitated by the following means.

ESTABLISH MEANINGFUL RELATIONSHIPS OUTSIDE THE GROUP

If people are taught to establish meaningful relationships with others as a function of the group, there is less chance the clients will be dependent on the counselor. Clients will then be able to establish the personal relationships they need outside the group. They will then move into new relationships or improve the relationships they have outside the group. When new or improved relationships are established, the client will cease to depend on the group to meet these needs.

CLIENTS CAN SEE THE COUNSELOR WITHOUT HAVING A PROBLEM

Invite the clients to drop by just to chat or pass time. Let them know that they don't need to have a problem to talk to you.

CONDUCT EXERCISES

Exercises should be accomplished to reveal and preclude return situations. This is the principle of positive practice — having them act out in the group those behaviors that will take better care of them upon leaving the group. For example: Go around the group and ask persons to tell what they have learned and how they might cop out on that learning. Then lead a discussion on how to prevent cop-out. Have the clients role-play situations that previously they would have had difficulty with. Let them role-play one or two good endings to the situation.

EXERCISE V

Complete the following exercise.

1. Why is it important for clients to establish meaningful relationships outside of groups?

2. Is it important for clients to have a problem in order to see the counselor? If not, why not?

3. What is the principle of positive practice?

SUMMARY

Group counseling is the most effective method for counseling clients, with few exceptions. It is the best method for working with drug/alcohol clients. This study guide has provided you sufficient knowledge to identify four behaviors that clients need to learn in groups. Those behaviors were: separate thoughts and feelings, give and receive feedback, stay in the here and now, and own thoughts and feelings.

Equally as important were the two statements requiring intervention: "Someone else must change in order to solve member's problem." and statements designed to perpetuate the past. The principle of invitational counseling states that "Counselors can't make clients do things." There were three other parts to this principle: invite clients to responsibility and taking better care of themselves, invite responsibility by building on strengths, and invite responsibility by inviting selfishness.

Counselors should prepare themselves prior to starting a group by asking themselves four questions: "What is the purpose of the group?" "How do I want that purpose to happen?" "How can I give that message?" and "How will I invite clients to take responsibility for themselves?"

Group closure is just as important as opening a group. The three things that counselors need to teach their clients in order to bring about good group closure were: establish meaningful relationships, let clients know that they can see you without having a problem, and conduct exercises.

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Croup counseling will be one of your primary modes of rehabilitative counseling. Knowing your responsibilities and role as a counselor and facilitator will enhance the effectiveness of your group counseling sessions.

ANSWERS TO EXERCISES

EXERCISE I

1. By avoiding "why" questions.
2. When they learn to give and receive feedback.
3. By owning their thoughts and feelings.
4. By distinguishing thoughts from feelings.

EXERCISE II

1. When clients make statements implying someone else is responsible or statements designed to perpetuate the past.
2. "I've always been like this."
3. "If only my wife would stop nagging me."

EXERCISE III

1. Counselors can't make clients do things.
2. Ask clients to be responsible for themselves and to take better care of themselves.
3. Stroke members for what is wanted.
4. By asking, "What would you like to get for you out of being here?"

EXERCISE IV

1. Prior to starting a group.
2. To decide how the group is going to meet its objectives.
3. By being consistent in what they say and do.

EXERCISE V

1. To decrease dependency on the facilitator.
2. No, they can drop by just to chat.
3. Conduct exercises which act out in group those behaviors that take better care of clients' selves.

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SOCIAL ACTIONS TRAINING BRANCH
Lackland Air Force Base, Texas 78236

INTERPERSONAL COMMUNICATION

LP BB-VI-1.2 (9)
1 August 1978

STUDENT NAME _____ RANK _____

INSTRUCTOR _____ DATE _____ GROUP _____

CRITERION OBJECTIVE: 1g. In the day-to-day interaction in the school environment, participate in a manner which demonstrates characteristics conducive to constructive and healthy communication in accordance with the criteria listed on the Interpersonal Communication Performance Test.

	DAY 18	DAY 26	DAY 40
1. Exhibit a willingness to participate in the learning environment.			
a. Share thoughts.			
b. Share feelings.			
2. Demonstrate an attentive, inquiring, and questioning orientation to the learning process.			
a. Attentive.			
b. Listens to others.			
c. Attends to issues at hand.			
3. Demonstrate a genuine acceptance of feedback on how his/her behavior affects others, to include verbal and nonverbal expressions of feelings/ attitudes.			
a. Openness.			
b. Non-defensiveness.			
c. Staying in the "here-and-now."			
4. Provide appropriate feedback to others.			
a. Specific behavior (no personal attacks).			
b. Timeliness (near to event).			
c. Behavior that others can change (have control over).			
d. Personal expressions of his/her feelings about observed behaviors.			
e. Validation of behavior as appropriate (check out with others).			
5. Takes responsibility for his/her own behavior (offer statements showing ownership).			
a. I feel.			
b. I think - rather than presenting or repeating other peoples' views.			
6. Demonstrate an ability to differentiate between and become aware of behavior that: (1) expresses feelings and (2) expresses thoughts; that is, the ability to distinguish between cognitive ("idea") processes and emotional expressions.			
7. Respond to "here-and-now" data-what is happening in the group at the present time (what is going on in the group) as opposed to the "there-and-then" behavior - referring to "back-home" concerns, or behavior shown by people not in the immediate groups.			
8. Demonstrate a respect for the feelings of others in the group, even when his/her feelings are not congruent with those expressed. Criticism or derogatory comments about others' feelings are not appropriate; such as "putting down" others for their expressions of anger, anxiety, affection, etc.			
9. Demonstrate a willingness to attempt to understand and reflect empathize with others' expressions of feelings.			
10. Reflect (summarize or clarify) ideas or suggestions offered by other group members - able to pull together (organize) content information by group members.			

_____ _____ _____
Student's Acknowledgement Final Date Student Initials

All items must be satisfactory by Day 40 to receive an overall satisfactory passing grade for CO 1g.

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S = Satisfactory

NI = Needs Improvement

U = Unsatisfactory

N/O = Not observed

GROUP PROCEDURES

To receive an overall satisfactory for Task Functions, you must receive four satisfactory ratings by Day 26 Task Functions. The same applies to Maintenance Functions. There can be no unsatisfactories by Day 26. You must receive satisfactory in both Task and Maintenance Functions. Criterion Objectives 1c and 1d.

Student's Signature Final Date

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SOCIAL ACTIONS TRAINING BRANCH
Lackland Air Force Base, Texas 78236

LP-BB-VI-1.2(3)
1 August 1978

TASK & MAINTENANCE FUNCTIONS PERFORMANCE TEST

FINAL EVALUATION

STUDENT NAME _____ RANK _____ DATE _____

INSTRUCTOR _____ GROUP _____

TASK FUNCTIONS

1c. CRITERION OBJECTIVE: In a small group setting demonstrate an ability to manage group task functions in accordance with the criteria tested on the Task and Maintenance Functions Progress Test.

	DAY 18	DAY 26
SETTING GOALS (Suggests objectives for the group on which to work.)	____	____
SOLVING PROBLEMS (Suggests steps for resolving problems, demonstrates capability to analyze problems.)	____	____
MAKING DECISIONS (Decides between alternative suggestions for group action.)	____	____
INTEGRATING IDEAS (Ties ideas together logically, joins parts to form a whole.)	____	____
TESTING CONSENSUS (Checks out with all members of the group their opinions about goal and objectives.)	____	____
BEING INVENTIVE (Offers unique suggestions for group on which to work.)	____	____
BEING IN CONTROL (When group is dragging (apathetic), initiates action, takes own responsibility.)	____	____
BEING PRODUCTIVE (Offers a variety of ideas to group.)	____	____
FINAL TASK FUNCTIONS GRADE		____

MAINTENANCE FUNCTIONS

1d. CRITERION OBJECTIVE: In a small group setting, demonstrate group maintenance functions in accordance with the criteria listed on the Tasked Maintenance Functions Performance Test.

STIRRING THINGS UP (Catalyst, provocative.)	____	____
HARMONIZING AND COMPROMISING (Brings together conflicting ideas; looks for common group concerns.)	____	____
ENJOYING THE PROCESS (Shows excitement, involvement, and eagerness.)	____	____
GIVING INTERPERSONAL FEEDBACK (Provides appropriate feedback to others about their behavior in the group.)	____	____
HELPING OTHERS CONTRIBUTE (Invites other group members to participate, "gate-keeping.")	____	____
ACCEPTING OTHERS' FEELINGS (Verbal expression, exhibits tolerance, is not critical of other members' feelings.)	____	____
EXPRESSING GROUP FEELINGS (Shares perception about the group — anxious, apathetic, dependent.)	____	____
REVIEWING GROUP PROCESS (How the group is functioning; i.e., how group is making decisions, are all the members participating, and who controls the group.)	____	____
FINAL MAINTENANCE FUNCTION GRADE		____

_____
Student's Signature Final Date

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Attachment 3

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S = Satisfactory

NI = Needs Improvement

U = Unsatisfactory

N/O = Not observed

GROUP PROCEDURES

To receive an overall satisfactory for Task Functions, you must receive four satisfactory ratings by Day 26 Task Functions. The same applies to Maintenance Functions. There can be no unsatisfactories by Day 26. You must receive satisfactory in both Task and Maintenance Functions. Criterion Objectives 1c and 1d.

Student's Signature Final Date

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Social Actions Training Branch
Lackland Air Force Base, Texas 78236

LP 3ALR73430B/3OLR7361B/
3OZR7364B-VI-1.1(5)
1 August 1978

WHAT TO LOOK FOR IN GROUPS

This worksheet is designed to assist group members in understanding and being more perceptive about group process.

1. PARTICIPATION

Who are the high participators?

Who are the low participators?

Do you see any shift in participation:
a. Highs become quiet; lows become talkative.
b. Do you see any reason for this in the group's interactions?

How are the silent people treated?
How is their silence interpreted?
a. Consent.
b. Disagreement.
c. Disinterest.
d. Fear.

Who talks to whom?
Do you see any reason for this in the interaction?

Who keeps the ball rolling?
Why?
Do you see any reason for this in the interaction?

2. INFLUENCE

Which members are high in influence?

Which members are low in influence?

What shifts of influence do you see?

Do you see any rivalry in the group?

Is there a struggle for leadership?

What effect does this struggle have on the group?

3. STYLES OF INFLUENCE

a. Autocratic.
(1) Does anyone attempt to impose his/her will on other group members or try to push them to support his/her decisions?

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(2) Who evaluates or passes judgment on other group members?

(3) Do any members block action when it is not moving in the direction they desire?

(4) Who pushes to get the group organized?

b. Peacemaker.

(1) Who eagerly supports other group members' decisions?

(2) Does anyone consistently try to avoid conflict or unpleasant feelings from being expressed by pouring oil on the troubled waters?

(3) Is any member typically deferential toward other group members? Gives them power?

(4) Do any members appear to avoid giving negative feedback (who will level only when they have positive feedback to give)?

c. Laissez-faire.

(1) Are any group members getting attention by their apparent lack of involvement in the group?

(2) Does any group member go along with group decisions without seeming to commit himself/herself one way or the other?

(3) Who seems to be withdrawn and uninvolved?

(4) Who does not initiate activity, participates mechanically, and only in response to another member's question?

d. Democratic.

(1) Does anyone try to include everyone in a group decision or discussion?

(2) Who expresses his feelings and opinions openly and directly without evaluating or judging others?

(3) When feelings run high and tension mounts, which members attempt to deal with the conflict in a problem-solving way?

(4) Who appears to be open to feedback and criticisms from others?

4. DECISIONMAKING PROCEDURES

Does anyone make a decision and carry it out without checking with other group members?

What effect does this have on other group members?

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Does the group drift from topic to topic?

Who topic-jumps?

Do you see any reason for this in the group's interactions?

Who supports other members' suggestions or decisions?

Does this support result in the two members deciding the topic or activity for the group?

How does this affect other group members?

Is there any evidence of a majority pushing a decision through over other members' objections?

Do they call for a vote (majority support)?

Is there any attempt to get all members participating in a decision? (Consensus)

What effect does this seem to have on the group?

Does anyone make any contributions which do not receive any kind of response or recognition (plop)?

What effect does this have on the member?

5. TASK FUNCTIONS

Does anyone ask for or make suggestions as to the best way to proceed or to tackle a problem?

Does anyone attempt to summarize what has been covered or what has been going on in the group?

Is there any giving or asking for facts, ideas, opinions, feelings, feedback, or searching for alternatives?

Who keeps the group on target?

Who prevents topic-jumping or going off on tangents?

6. MAINTENANCE FUNCTIONS

Who helps others get into the discussion (gate openers)?

Who cuts off others or interrupts them (gate closers)?

How well are members getting their ideas across?

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Are some members preoccupied and not listening?

Are there any attempts by group members to help others clarify their ideas?

How are ideas rejected?

How do members react when their ideas are not accepted?

Do members attempt to support others when they reject their ideas?

7. GROUP ATMOSPHERE

Who seems to prefer a friendly congenial atmosphere?

Is there any attempt to suppress conflict or unpleasant feelings?

Who seems to prefer an atmosphere of conflict and disagreement?

Do any members provoke or annoy others?

Do people seem involved and interested?

Is the atmosphere one of work-play satisfaction, taking flight, sluggishness, etc.?

8. MEMBERSHIP

Is there any subgrouping? Sometimes two or three members may consistently agree and support each other or consistently disagree and oppose one another?

Do some people seem to be "outside" the group?

Do some members seem to be "in"?

How are those outside treated?

Do some members move in and out of the group (lean forward or backward in their chairs, or move their chairs in and out)?

Under what conditions do they come in or move out?

9. FEELINGS

What signs of feelings do you observe in group members? Anger? Irritation? Frustration? Warmth? Affection? Excitement? Boredom? Defensiveness? Competitiveness? Etc.

Do you see any attempts by group members to block the expression of feelings, particularly negative feelings?

How is this done?

Does anyone do this consistently?

10. NORMS

Are certain areas avoided in the group (e.g., sex, religion, talking about present feelings in group, discussing the leader's behavior, etc.)?

Who seems to reinforce this avoidance?

How do they do it?

Are group members overly nice or polite to each other?

Are only positive feelings expressed?

Do members agree with each other too readily?

What happens when members disagree?

Do you see norms operating about participation or the kinds of questions that are allowed (e.g., "If I talk, you must talk"; "If I tell my problems, you have to tell your problems.")?

Do members feel free to probe each other about their feelings?

Do questions tend to be restricted to intellectual topics or events outside of the group?